KFMAM Manual - 10/1/05

01000: **Administrative Information** -

01100 Health Benefit Programs - Several health benefit programs are provided to low income Kansans to help cover the cost of health care.

1101 Medicaid - The Medicaid program is a joint federal/state-funded program that covers a majority of low income persons in the State including children and pregnant women. Policies for family related medical coverage are in this manual while polices for other medical programs are located in the KEESM.

1102 HealthWave 21 - The HealthWave 21 program is based on a federal block grant program and is intended to serve children under the age of 19 who are uninsured and who are not otherwise eligible for Medicaid.

01120 Basis of Programs and Policies - The Division of Health Policy and Finance (DHPF) in the Department of Administration has the responsibility to develop state plans for furnishing assistance and services to eligible individuals and to determine the general policies relating to the medical assistance programs. The Kansas programs are independent from programs administered in other states unless otherwise stated in this manual. An application for assistance in Kansas shall be treated as a new application.

Therefore, a new determination of eligibility rendered by another state shall not, in and of itself, affect eligibility in Kansas.

Policies set forth in this manual are based upon various federal and state statutes and administrative regulations. The following citations provide an overview of the primary statutory and regulatory references on which the programs are based.

Medicaid

-42 United States Code Annotated (U.S.C.A.), Subsection 1396a et seq.

-42 Code of Federal Regulations (C.F.R.), Parts 430 - 456

-Kansas Statutes Annotated (K.S.A.), 39-708c, 39-209(e)

-Kansas Administrative Regulations (K.A.R.), Chapter 30, Article 6

HealthWave 21

-Section 2103 of Public Law 105-32

-Kansas Administrative Regulations (K.A.R.), Chapter 30, Article 14

Fair Hearings

-42 Code of Federal Regulations (C.F.R.), Part 205

-Kansas Statutes Annotated (K.S.A.), 75-3306

-Kansas Administrative Regulations (K.A.R.), Chapter 30, Article 7

Confidentiality Policies

-Kansas Statutes Annotated (K.S.A.), 39-709b

-Kansas Administrative Regulations (K.A.R.), Chapter 30, Articles 2-11

This manual has been developed to implement the policies set forth in the above-mentioned statutes and administrative regulations. Thus, the provisions of the manual are to be followed by program staff when determining eligibility of applicants or recipients for assistance in accordance with K.A.R. Chapter 30, Article 2.

Providing assistance is a continuing and comprehensive process, embracing all parts of the administration of the welfare program. All of the steps or parts of the process are interrelated and must be planned for, and ultimately judged, in terms of the effectiveness of the complete administration.

01130 Staffing Standards -

1131 Volunteers - May be used in related activities such as outreach or assisting applicants in completing the application, other prescreening activities, and securing needed verification. Individuals and organizations who are parties to a strike or lockout and their facilities may not be used in the certification process except as a source of verification for information supplied by the applicant.

1132 Data Collection of Racial/Ethnic Categories - The Case Manager may request applicants to voluntarily identify their racial or ethnic status on the application form and shall inform the applicant(s) that this

designation shall not affect their eligibility.

The Case Manager may ask the applicant to identify his racial/ethnic origin during a telephone contact. However, there are certain stipulations that are necessary when the self-identification process is used in either the application process or a telephone contact.

1132.01 - Applicants shall be assured by the Case Manager that information is used for statistical purposes only in determining if the program is administered without discrimination. Racial/ethnic data shall have no effect on an applicant's eligibility to participate and it will not be used for discriminatory purposes.

1132.02 - The applicant shall be advised that the information is used to ensure that benefits are available to all eligible persons regardless of race, color, or national origin.

1132.03 - Applicants shall be advised that the information given will be confidential and, should they decide not to provide this information, such a decision will not have an adverse effect on determining their eligibility.

01200 Rights and Responsibilities -

1210 Rights of Applicant/Recipient -

1210.01 Right to Make Application - An individual shall have the right to make application regardless of any question of eligibility or agency responsibility. The right of an individual to make application may not be abridged.

1210.02 Right to Information - A client has the right to be provided with information concerning the types of assistance, which are provided by the agency. Upon request, the agency shall furnish the client with informational pamphlets and will explain to him/her the categories of assistance for which he/she may be eligible and the eligibility factors for each.

1210.03 Right to a Private Interview - A client has the right to a private interview whenever he/she is discussing his/her individual situation with the agency.

1210.04 Right to Receive a Prompt Decision - A client has the right to have a timely decision rendered on his/her application. See ^1405^. A recipient has the right to a decision rendered on any other formal request (such as a request for services or for information) within 30 days of its receipt by the agency.

1210.05 Right to Restored Benefits - If the client has been wrongfully delayed, denied, or terminated, he/she is due restored benefits.

1210.06 Right to Correct Amount of Assistance - The client, if eligible, shall be entitled to the correct determination of benefits based upon budgetary standards or allowances in accordance with agency policies.

1210.07 Right to Equal Treatment - All clients have a right to equal treatment in similar circumstances and no person shall be denied benefits or be subject to discrimination on the basis of race, color, or national origin, gender, religion, age, disability, political beliefs, sexual orientation, or marital or family status.

The client has the right to file a discrimination complaint with either the Federal or the State agency.

1210.08 Right to A Fair Hearing - A client has the right to request a fair hearing on any agency decision or lack of action in regard to his application for or receipt of assistance.

1210.09 Right to Withdraw from the Program - An applicant has the right to withdraw his application at any time between the date the application is signed and the date the notice of the agency decision is mailed. A recipient may withdraw from a program at any time.

1210.10 Right to an Individual Determination of Eligibility for Assistance - A client shall be given an opportunity to present his request and to explain his situation.

1210.11 Right to Written Notification of Action - A client has the right to a written notification of agency action concerning his eligibility for assistance.

1211 Responsibilities of Applicant/Recipient -

1211.01 Responsibility to Submit Identifiable Application - The applicant shall submit an application containing a legible name and address (unless homeless), and which has been signed.

1211.02 Responsibility to Supply Information - A client has the responsibility to supply, insofar as able, information essential to the establishment of eligibility.

Information which is "time-sensitive" and received in the office through a drop box, mail slot or other such manner at the opening of the business day shall be considered as received during the previous work day. Information which is received as a fax or copy, but is required in original form, shall be considered as received when the fax/copy arrives in the office provided the original document arrives in a timely manner as determined at the local level. In general, a fax or copy of a document shall be acceptable without requiring an original (including an application form or monthly report form). However, an original document shall be required for establishing age, identity and citizenship and alienage status, and when determined to be necessary based on prudent person judgment.

1211.03 Responsibility to Provide Verification - The client has primary responsibility for providing verification (certain exceptions to these requirements are specified in the verification section). See ^1325^.

1211.04 Responsibility to Authorize Release of Information - A client has the responsibility to give written permission for release of information when needed.

1211.05 Responsibility to Report Changes - Persons have the responsibility to report changes in circumstances within 10 calendar days from the date the change is known. See ^7211^ for specific changes that change reporting persons are required to report.

1211.06 Responsibility to Cooperate - The client shall cooperate with all program requirements and in supplying required information.

1211.07 Responsibility to Provide Social Security Numbers - Each applicant/recipient shall provide his/her Social Security

number. See ^2031^.

1211.08 Responsibility to Meet Needs - A client has the responsibility to meet his/her own needs insofar as he/she are capable.

1212 Responsibilities of the Agency - Upon request, the agency must explain the rights and responsibilities of clients and the following requirements placed on the agency.

1212.01 Periodic Reviews - The agency is required to make periodic reviews of eligibility if the application is approved. The agency shall notify the client of the expiration of the review period and shall send the client a new application prior to the last month of the review period.

1212.02 Fraud - The agency is required to investigate and refer for legal action any alleged fraud related to the receipt of assistance.

1212.03 Responsibility to Accept an Identifiable Application - The agency shall accept an application containing a legible name and address (unless homeless) and which has been signed. See ^1401^.

1212.04 Responsibility to Review Recipients Timely - The agency has the responsibility to process all subsequent applications timely so there will be no break in the benefits the client is eligible to receive.

1212.05 Responsibility to Establish Claims of Overpayment - The agency is responsible for establishing claims for overpayment (either fraud, client, or agency error).

1212.06 Responsibility to Restore Lost Benefits - The agency shall restore benefits to the client if benefits were wrongfully denied, delayed, or terminated.

1212.07 Responsibility for Giving Notice of Action - The agency is responsible for giving adequate and/or timely notice of action when appropriate.

1212.08 Case File Documentation - The agency has the responsibility

to insure that case file documentation supports the decision to provide, deny or change eligibility, benefits, or services.

1212.09 Cost-Effective Service Provision - Services shall be provided in the most cost-effective manner in order to provide the client with the appropriate services within the resources allowed.

01220 Confidentiality -

1221 Confidentiality of Information Concerning Applicants or Recipients - Information concerning applicants or recipients (present and past) is confidential and may not be disclosed to another SRS employee, the client, or any other nonagency personnel except as set forth in this section.

Information concerning clients or providers who have been referred for investigation is confidential and may not be released unless the Fraud Unit or the prosecuting attorney to whom the case has been referred for legal action authorizes such disclosure.

1222 Disclosure of Confidential Information - The agency may disclose confidential information when the purpose of such disclosure is directly related to: (1) the administration of the DHPF program; (2) an investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the DHPF program or the SSI program; or (3) the administration of any federal or federally assisted program which provides assistance (in cash or in kind) or services directly to individuals on the basis of need. For exceptions see ^1225^ and ^1226^.

Throughout this material related to confidentiality of case records, the term DHPF and SRS employees includes contracted employees (e.g., MAXIMUS employees responsible for HealthWave determinations).

1223 Nature of Information to be Safeguarded - The confidential nature of the following information must be safeguarded:

1223.01 - Names and addresses, including lists of applicants or recipients.

1223.02 - Information contained in applications, reports of investigations, reports of medical examinations, correspondence, and other records concerning the condition or

circumstances of any person for whom or about whom information is obtained, and including all such information whether or not it is recorded; and

1223.03 - Records of agency evaluations of such information. General information, not identified with particular individuals, such as total expenditures made, number of recipients, and other statistical information and social data contained in general studies, reports, or surveys of welfare problems, does not fall within the class of material to be safeguarded.

1224 Disclosure of Information to Client - Information entered in the case record is to be made available to the client upon request, for inspection at a time mutually agreeable to the agency and the client, except as set forth below.

1224.01 Information Provided by Other SRS Programs - Information provided by other SRS programs, such as Children and Family Services, Rehabilitation Services, Food Stamp services, Cash Services, and Substance Abuse, Mental Health & Developmental Disabilities is not to be made available to the client unless the respective program regulations authorize such disclosure.

1224.02 Medical and Psychiatric Reports - Medical and psychiatric reports are not to be made available to the client unless signed, written consent is obtained from the medical practitioner who rendered such report.

1224.03 Names and Addresses of Complainants - The names and addresses of complainants are not to be made available to the client.

1224.04 Investigative Reports - Investigative reports concerning welfare fraud or other types of overpayments are not to be made available to the client during the course of the investigation or during the time period in which the case has been referred for legal action unless the Fraud Unit, Legal Division or the prosecuting attorney to whom the case has been referred for legal action authorizes such disclosure.

NOTE: With the exception of ^1224.03^, all documents and records to be used by the agency at a fair hearing are to be made available, upon request, to the appellant or his

representative for inspection and/or copying at a reasonable time mutually agreeable to the agency and the client or his representative prior to the date of the hearing.

1225 **Disclosure of Information to Agency Personnel** - Information is not to be disclosed to another DHPF or SRS employee unless the employee has a need for the information in the performance of his official duties. The client's signature on the application form authorizes the disclosure of information concerning a MA/CM, EM, WT, GA, Refugee, Child Care, Medicaid, HealthWave 19 and 21, and/or Food Stamp client if the purpose of such disclosure is connected with the administration of any of the aforementioned programs, the Child Welfare or Child Support programs (under titles IV-B, IV-D, and XX), or any other federal or federally assisted program which provides assistance, in cash or in kind, or services directly to individuals on the basis of need. (Example: SSI, LIEAP.)

1226 **Disclosure of Information to Nonagency Personnel and the Public** - Information is not to be disclosed to nonagency personnel such as courts, school boards, legislators, prosecuting attorneys, policemen, FBI agents, doctors, social service agencies, state employment offices, public housing authorities, landlords, creditors, relatives, etc., except as set forth below.

1226.01 **Information Available to the Public** - Information Available to the Public - Regulations, Plans of Operation, state manuals, and federal procedures, which affect the public, shall be maintained in the office of the Division of Health Policy and Finance for examination by members of the public on regular workdays during the regular office hours.

1226.02 **Directly Related to the Administration of DHPF Programs** - Information may be disclosed to nonagency personnel when the purpose of such disclosure is directly related to the administration of DHPF programs or assisting SRS in the administration of there programs. The information concerning a cash, medical, child care, or food stamp client is not to be disclosed without the signed written consent of the client unless the purpose of such disclosure is directly related to one of those programs. Any information disclosed is to be limited to that which is reasonably necessary to accomplish the purpose of such disclosure. Such purposes include establishing eligibility, determining amount of assistance, and providing services to applicants or recipients.

In the course of providing services to clients, disclosure of information should be made to representatives of other welfare agencies or programs only when they can give assurance that:

(1) - the confidential nature of the information will be preserved;

(2) - the information will be used only for the purposes for which it is made available (such purposes should be reasonably related to the purposes of the DHPF program and the functioning of the inquiring agencies); and

(3) - the standards of protection established by the agency to which the information is disclosed are equal to those established by DHPF itself, both with regard to the use of information by staff and the provision of protective office procedures.

1226.03 **Federal or Federally Assisted Programs** - Information concerning clients is to be disclosed to federal or federally assisted programs which provide assistance (in cash or in kind) or services directly to individuals on the basis of financial need if the requesting agency certifies in writing that the information so requested is necessary to the administration of its program. Example: SSI.

1226.04 **Officials Conducting An Investigation, Prosecution, or Criminal/ Civil Proceeding** - Information is to be disclosed to the official conducting an investigation, prosecution or criminal or civil proceeding in connection with the administration of the DHPF program if such information is reasonably necessary to the investigation, prosecution or criminal or civil proceeding. This includes welfare fraud investigations and prosecutions. The client's signature on the application/redetermination form authorizes the disclosure of information from the case record necessary to conduct an investigation, prosecution, criminal or civil proceeding related to eligibility for medical assistance.

Information concerning clients is to be disclosed to the official conducting an investigation, prosecution or criminal or civil proceeding in conjunction with the administration of the SSI program if such information is reasonably necessary to the investigation, prosecution, or criminal or civil proceeding.

Information disclosed pursuant to the above paragraphs shall be

provided the appropriate official in the following manner:

(1) - The official requesting such information shall be allowed to review pertinent case record material in the agency office during normal working hours.

(2) - Such official, upon request, shall be furnished with copies, or authenticated copies, or originals of pertinent case record materials as necessary at no cost. Prior to the release of an original document, a copy of the document shall be placed in the case record with a notation as to the disposition of the original.

If a question arises as to the pertinency of any requested material, consult the DHPF Legal Division.

1226.05 **Intention to Commit Crimes** - Information concerning the intention of a client to commit a crime and the information necessary to prevent the crime shall be disclosed to the appropriate authorities.

1226.06 **Fleeing Felons and Probation/Parole Violators** - The address of any member of a MA/CM household shall be made available, on request, to any Federal, State, or local law enforcement officer if the officer furnishes the name of the individual and notifies the agency that the individual:

(1) - is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony; or

(2) - is violating a condition of probation or parole imposed under Federal or State law; or

(3) - has information that is necessary for the officer to conduct an official duty related to item (1) or (2) above.

The officer must notify the agency that locating or apprehending the member is an official duty and that the request is being made in the proper exercise of an official duty.

1226.07 **Information Not Otherwise Authorized to be Disclosed** - Information not otherwise authorized to be disclosed by this provision may only be disclosed if the client has the authority to disclose such information and the agency has a signed,

written consent on file authorizing the agency to disclose the information to the specific person requesting such information, excepting that such information may be disclosed without signed, written consent in an emergency situation such as death or other serious crises to an appropriate person if the agency deems such unauthorized disclosure to be in the best interest of the client. If such information is disclosed without signed, written consent, the client shall be notified of such disclosure as soon thereafter as possible.

1227 **Subpoenas and Testifying in Court Concerning Information Not Otherwise Authorized to be Disclosed** - Since all information relative to a client is by law confidential and since clients are advised that any information they reveal is held confidential, any information received by the Case Manager or other person connected with the agency, is by statute, in the nature of a privileged communication just as is the information received by an attorney or physician from his client, or received by a minister in the performance of his function as a spiritual advisor.

The Legal Division must be notified immediately of a subpoena to produce records or of a court order to testify; such notice should be in writing whenever time permits. A staff member who is subpoenaed or whose records are subpoenaed, unless otherwise instructed by the Legal Division, should make appearance at the time and place stated in the subpoena, and should bring the records subpoenaed with him, if any.

After being sworn in he should make the following statement to the court in response to the first material question:

"I am attending the court's hearing as a result of a subpoena. The law and DHPF policy require that I call the court's attention to the laws and regulations limiting use and disclosure of information concerning public assistance. K.S.A. 39-709b limits the use or disclosure of information concerning applicants and recipients of assistance to purposes directly connected with the administration of the assistance program, unless there is written consent given by the consumer. These federal laws and regulations also similarly limit use and disclosure":

1227.01 - Section 1902(a)(7) of the Social Security Act, codified at 42 U.S.C. Sec. 1936a(a)(7), and 42 C.F.R. Sec. 431.300, et seq. (the Medicaid Program);

The witness will submit the above statement in its entirety to the court and a copy to the attorney and will testify further

according to the ruling and instructions of the court. Testifying and releasing confidential information when ordered to do so directly by a judge in an in-court setting is not considered unauthorized disclosure of information. See ^1229^.

1228 Questions Concerning Disclosure of Information - When there is some question as to the disclosure of information to another DHPF and SRS employee, the client or other nonagency personnel, the question is to be referred to the legal division for clearance.

1229 Unauthorized Disclosure of Confidential Information - A DHPF employee who discloses confidential information concerning an applicant or recipient (present and past) in violation of the provisions set forth in ^1220^ and subsections shall be subject to appropriate disciplinary action (official reprimand, suspension, demotion, dismissal, etc.).

Further, any individual who discloses confidential information concerning an applicant or recipient (present, past) in violation of the provisions set forth in ^1220^ and subsections shall be subject to criminal prosecution, and if convicted, may be fined up to $1,000 and/or sentenced to the county jail for a period not to exceed six months.

01300 Prudent Person - The local Case Manager shall use the prudent person concept in administering the Medical Programs. The phrase, "prudent person" applies to the particular situation that indicates further verification of information is needed. It also applies to the reasonableness of judgments made by an individual in a given situation based on that individual's experience and knowledge of the program.

1310 Staff Responsibility - Staff must be prudent when the circumstances of a particular case indicate the need for further inquiry. Additional substantiation or verification should be obtained whenever the information provided by the applicant or recipient is incomplete, unclear, or contradictory.

Circumstances that require a more thorough analysis of a case include:

1310.01 - An individual who is living at a higher standard of living than known resources or income would permit.

1310.02 - An individual who appears to qualify for potential resources such as Social Security, unemployment benefits, veterans' benefits, medical insurance, etc.

1310.03 - An individual who appears to be confused.

1310.04 - An individual who has a history of providing conflicting or incomplete information.

1310.05 - Documents (birth certificates, Social Security cards, etc.) that appear to have been altered.

01320 Simplified Eligibility - As adopted by the State is a system by which the agency accepts the individual's statement as the basis of eligibility. For some factors of eligibility, additional information will have to be obtained.

1321 - The agency shall use, to the greatest extent possible, the information on the application/redetermination form, as provided by the individual applicant/recipient, for purposes of determining eligibility and extent of entitlement.

1321.01 - Carefully review the form for completeness, clarity, consistency, and lack of error or questionable statement.

1321.02 - Give the applicant/recipient the opportunity to present additional clarification when information on the form is incomplete, unclear, or inconsistent, or where other circumstances in the particular case indicate to a prudent person that further inquiry needs to be made. Negative action as a result of failure to provide the information can be taken only when written notice was given allowing at least 10 calendar days from the date the notice is initiated to return the information.

1321.03 - Consider additional information from agency records.

1321.04 - Advise the applicant/recipient when it is necessary for the agency to go to other sources, and when necessary obtain his consent on the information release form. If he does not consent to the necessary contacts, it may not be possible to determine that initial or continuing eligibility exists. Each applicant and recipient gives consent to a full field investigation when he signs the application/redetermination form, but a signed informational release form may be necessary to obtain the needed information. See ^1211.04^.

1322 Sources of Verification -

1322.01 Documentary Evidence - Shall be used as the primary source of verification. Documentary evidence consists of a written confirmation of a household's circumstances. Examples are wage stubs, rent receipts, utility bills, medical reimbursement statements, and, for Social Security numbers, such evidence as BENDEX printouts, Social Security cards, or any official document containing the Social Security number.

Although documentary evidence shall be the primary source of verification, acceptable verification shall not be limited to any single type of document and may be obtained through the household or other sources.

Alternate sources of verification, such as collateral contacts shall be used whenever documentary evidence cannot be obtained.

1322.02 Collateral Contacts - A collateral contact is a verbal confirmation of a household's circumstances made by a person outside of the household. The collateral contact may be made either by mail or over the telephone. The acceptability of a collateral contact shall not be restricted to a particular individual but may be anyone who can be expected to give an accurate third party verification of the household's statements. Examples of acceptable collateral contacts are employers, landlords, social service agencies, migrant service agencies, and neighbors of the household.

1322.03 Discrepancies - Where information from another source contradicts statements made by the household; the household shall be afforded a reasonable opportunity to resolve the discrepancy prior to an eligibility determination. Information needed to resolve the discrepancy shall be requested from the household, however, if the household fails to provide the necessary information, staff may elect to verify the information directly. Households are to be given 10 days to provide necessary verification. If the client does not or refuses to provide adequate verification to resolve the discrepancy, the case may then be closed or the application denied if that is the appropriate case action.

1323 Responsibility for Obtaining Verification - The household has the primary responsibility for providing documentary evidence to support its statements and to resolve any questionable information. Households may supply documentary evidence by mail, Fax or by an authorized or personal representative. Any reasonable documentary evidence provided by the household shall be accepted by the local office/CH (Clearinghouse). The local office/CH shall be Primarily concerned with how adequately the verification proves the statements on the application. If it would be difficult or impossible for the household to obtain documentary evidence in a timely manner, the Case Manager shall offer assistance to the household in obtaining documentary evidence in a phone call and/or send a notice that includes the offer of assistance to all.

1323.01 - The household shall not be held responsible when a person outside of the household fails to cooperate with a request for verification.

1324 Documentation - Case files must contain documentation to support the determination to approve or deny program benefits. Documentation means that a written statement regarding the type of verification and a summary of the information obtained has been entered in the case record. Such statements must be in sufficient detail so that a reviewer would be able to determine the reasonableness of the determination. For example, when income is verified by the presentation of pay stubs, the gross amount of income on each pay stub, and the frequency of receipt of income are included on a copy of the pay stub in the case record or are recorded by the Case Manager elsewhere in the case file.

Where verification was required to resolve questionable information, the Case Manager shall document why the information was considered questionable and how the questionable information was resolved. The Case Manager shall also document why any alternate sources of verification were needed and, if a collateral contact was rejected, the case file shall contain documentation of why the collateral contact was rejected and an alternate chosen.

1325 Verification Provisions - Verification is the use of documentary evidence & collateral contacts to establish the accuracy of statements on the application.

1325.01 Mandatory Verification That Affects Eligibility for Program Benefits - The Case Manager shall verify the following information prior to approval for clients initially applying:

(1) - Gross Nonexempt Income - Shall be verified prior to approval. However, where all attempts to verify the income have been unsuccessful because the person or organization providing the income has failed to cooperate with the household and the Case Manager, and all other sources of verification are unavailable, the Case Manager shall determine an amount to be used based on the best available information.

(2) - Alien Status - The Case Manager shall determine from information on the application if clients identified, as aliens are eligible aliens, as defined in ^2042^, by requiring that verification be presented for each alien client. If the verification of alien status is not provided for any alien client, that person shall be disqualified until the necessary verification of his/her status is provided. This requirement does not apply to aliens seeking emergency medical services coverage per KEESM 2691.

See KEESM 4100 for treatment of income for an alien excluded from the program under this provision.

Alien applicants must be given a reasonable opportunity to submit documentary evidence of their eligible alien status prior to any action being taken to reduce, deny, or terminate eligibility or benefit level. A reasonable opportunity shall be at least 10 days from the date of the agency's request for an acceptable document. If the 10-day period ends before the timely processing deadline and documentation has not been submitted, the applicant may not be approved until the documentation is submitted. If the 10-day period will end after the timely processing deadline and the household is otherwise eligible, benefits must be provided within normal or expedited time frames as appropriate.

(3) - Social Security Numbers - When an applicant who is required to apply for a Social Security number wishes to apply through the Social Security Administration, the individual shall be required to supply verification of application for the required SSN prior to the agency's certification of that individual unless the individual claims good cause. See ^2033^.

1325.02 Mandatory Verification That Affects Program Benefits - The following information shall be verified prior to a determination of the benefit amount for households initially applying. Failure to provide verification of these items is not

grounds for denial, rather the application would be processed without allowing a deduction for the claimed expense.

(1) - Medical Expenses - Medical expenses used to meet spenddown. The amount of any medical expenses shall be verified prior to initial approval.

(2) - Dependent Care Expenses (MA CM Only) - All payments made for dependent care must be verified prior to certification. If verification is not provided, the expenses shall not be allowed. If a portion of the expense is verified, that amount shall be allowed. If verification is provided later, the verification shall be treated as a change in circumstances and the household's benefit shall be redetermined with the updated verification. Also See ^6230^.

1326 Verification of Questionable Information - The Case Manager shall verify all other factors of eligibility prior to approval only if they are questionable and affect the household's eligibility. To be considered questionable, the information on the application must be inconsistent with other information on the application or previous applications or inconsistent with information received by the agency. When determining if information is questionable, the decision shall be based on each household's individual circumstances. Also see ^1310^ and ^1320^.

1326.01 Household Composition - If questionable, the Case Manager shall verify any factors affecting the composition of a household.

1326.02 Citizenship - When a household's statement that one or more of its members are U.S. citizens is questionable, the household shall be asked to provide acceptable verification. See ^2043^. If the household is unable to provide this verification, the member whose citizenship is questionable shall be excluded from participation until verification of his/her U.S. citizenship is provided. See KEESM 4100 for treatment of the income and resources of a person excluded under this provision.

01400 Application Process/General Information -

1401 General Information - Submittal of a signed paper application or an on-line application shall be considered a request for assistance.

Based on the provisions of ^3000^, an application shall include all persons who are required to be in the assistance plan. This includes those persons who later join an existing assistance unit such as an older child, or a returning absent parent.

The application form together with the Case Manager's records (if any), the necessary forms (budgets, notices of action, narratives, etc.), and any required verification must substantiate eligibility or ineligibility.

At the time of application processing, each month shall be viewed separately in determining eligibility or ineligibility. For example, if an application is filed in July but processed in August, ineligibility in August shall not effect the eligibility determination for the month of July.

Applications for either Medicaid poverty level coverage (HealthWave 19) (see ^2270^) or HealthWave 21 coverage (see ^2400^) for children can be filed via the HealthWave application. Such applications are to be mailed to the HealthWave Clearinghouse and can also be accepted at the local SRS office. A central HealthWave Clearinghouse has been established to determine eligibility for either of these programs if the family is accessing only Medicaid poverty level or HealthWave medical benefits for children. The current contractor managing the Clearinghouse is MAXIMUS. If the family accesses other benefits such as food stamps or childcare, eligibility could be established at the local SRS office and managed at the Clearinghouse.

1402 **How to Apply** - Application forms can be requested from any local SRS office, SRS access site, or the HealthWave Clearinghouse. An application can be filed in person, by mail, or electronically by fax or computer. Each household has the right to file an application on the same day it contacts the SRS office during office hours or mails the application to the HealthWave Clearinghouse.

When an application is requested in person, the local office shall encourage the household to file the application that same day. When an application is requested from the local office over the telephone, the local office shall encourage the applicant to appear in person and file the application that same day, or offer to mail the application that same day, when possible, or the following business day. When an application is requested over the telephone from the HealthWave Clearinghouse, it shall be mailed the same day, when possible, or the following business day. When an application is requested in writing, the local office or HealthWave Clearinghouse shall mail an application to the household the same day the request is received, when possible, or the following business day.

NOTE: If the applicant household is homeless and they have no street address to list, the application shall be so noted and accepted by the agency.

For ongoing recipients who apply for additional assistance under a different program (e.g., a medical recipient who requests cash assistance) and for situations in which an additional program is added to a pending application based on a client's request, the following provisions shall apply:

NOTE: The provisions below are not applicable to instances in which the agency initiates the new program, e.g., closing TAF but continuing medical for a pregnant woman.

1402.01 - If the new program is requested within the month following the month of application, or in the first month of the new review period, neither an application nor signature is required.

1402.02 - If the new program is requested after the month following the month of application or after the first month of the review period, an application is required.

1402.03 - If a request is made for a new medical program after the month following the month of application or after the first month of the new review period and there are less than six months left in the current review period, an application is required.

1403 **Application date** - The date of receipt in a local SRS Service Center or the HealthWave Clearinghouse (for the HealthWave program and some Medicaid programs) of a signed paper application is considered the application date for establishing initial eligibility. Giving a signed paper application to an SRS worker during a face-to face- interview at an off-site location, such as a home visit or at an SRS Access Point, shall also establish the date of application.

Note: Date stamping of an application by an SRS Access Point does not constitute a date of receipt for application processing.

For an on-line application, the date the application is submitted on-line shall be considered the application date for establishing initial eligibility if the signed signature page is received in the local SRS office or the HealthWave Clearinghouse within 10 calendar days following the date the on-line application is submitted. Signature pages can be returned by

fax as well as mail. If the signature page is not received within 10 calendar days of the date the on-line application is submitted, the application shall be denied see ^1406.02^(6). The on-line application shall be registered in KAECSES when received prior to receipt of the signature page.

When an applicant indicates that he or she is unable to print the signature page of an on-line application, the local SRS office or the HealthWave Clearinghouse is responsible for mailing the applicant the signature page. The signature page shall be mailed on the same day the on-line application is submitted if submitted on a workday during business hours. The consumer must then sign and return the page within 10 calendar days or the application shall be denied as noted above.

When the on-line application is submitted after hours or on a weekend or holiday, the signature page shall be mailed on the first workday following the date the application is submitted.

For information regarding a faxed or copied application form see ^1211.02^.

1404 Who May File - An application for assistance shall be made by the individual in need or by another person able to act in the individual's behalf. See ^2010^. If the applicant or his representative signs by mark, the names and addresses of two witnesses are required. Obtaining the signatures of all persons in the family group who are requesting assistance and able to act in their own behalf per ^2010^ is encouraged, but cannot be required.

1404.01 Filing on Behalf of a Deceased Person - For medical, an application may be made on behalf of a deceased person by any responsible person. Application must be made in the month of death or within the three following months.

1404.02 Filing for Institutionalized Individuals - When possible, all necessary information and signed forms will be obtained by institutional personnel. Parents, spouses, guardians/conservators and others who may apply on behalf of the individual per ^2010^ must always be given the opportunity to apply on behalf of an institutionalized person not able to act in his own behalf. If institutionalized personnel are unable to obtain the required forms from the patient or any of the above individuals, the administrator of a licensed facility may apply on behalf of the patient. General hospitals are not regarded as a

licensed facility for this purpose.

Complete applications will be forwarded to the SRS office or CH for processing.

All information pertinent to eligibility and known by institutional staff will be communicated to the local office. When the institution acts as an employer to the patient, institutional personnel will be responsible for reporting all earnings to the local SRS office.

Generally the local SRS office where the institution is located will process new applications. However, when appropriate, the local office or CH shall determine whether the individual is currently included on an open medical case before processing. If the individual is included on a currently open case, the application shall be denied. The referral and a copy of the application shall be sent to the current county or CH where the appropriate case action will be taken to certify eligibility to the institution. (See ^7300^) For individuals who currently have an unmet spenddown, the institution should be notified as no FFP can be claimed until the spenddown is met. Medical expenses incurred at the institution shall be considered toward the unmet spenddown and eligibility certified when the spenddown is met.

1404.03 **Withdrawing the Application** - The household may voluntarily withdraw its application at any time. The agency shall document in the case file the reason for withdrawal, if any was stated by the household, and that contact was made with the household to confirm the withdrawal. The household shall be advised of its right to reapply at any time subsequent to withdrawal.

1404.04 **Universal Access** - An individual or family can apply for benefits where they choose. All family medical cases will be transferred to and maintained by the HealthWave Clearinghouse once processed. The SRS Service Center where the application is filed shall inform the consumer about the transfer to the HealthWave Clearinghouse.

1405 **Time In Which Application is to be Processed and Case Disposition** - All applications shall be approved or denied on a timely basis except when a determination of eligibility cannot be made within the required period due to the failure of the applicant or collateral to provide required information. Written notice must be given to the applicant by the end of

the required period giving the reason(s) for the delay. The approval of an application from an alien who is otherwise eligible may not be delayed beyond the timely processing time frame due solely to the fact that no USCIS response to a request for verification of immigration status has been received.

Timely action is defined as follows:

1405.01 Medicaid Poverty Level and HealthWave - Within 15 calendar days of receipt of a completed application and all necessary supporting documentation; but no later than 45 days.

For pregnant women entitled to expedited service, the application shall be processed so the pregnant woman receives a medical card no later than 10 calendar days from the date of application. See ^1407^.

1405.02 All Other Medical Applications - Within 45 days of the agency's receipt of a signed application. For management purposes the agency shall strive to process applications within 30 days.

1406 Disposition of Applications - Disposition of Applications - The purpose of this section is to provide instructions regarding the procedures that follow the determination of eligibility or ineligibility for assistance. Eligibility/ineligibility is certified using KAECSES procedures. A copy of the Notice of Action is to be sent to medical providers to certify eligibility/ineligibility on medical cases when required.

One of the following case actions must occur within the established time period outlined in ^1405^.

1406.01 Approval - A notice of approval shall be sent for all programs determined eligible. Notices must contain the program approved for and the beginning and ending dates of the review period.

The application will be approved for medical, if automatically eligible, or if determined eligible with respect to all factors including financial.

(1) - Approved - Suspended - If the applicant is eligible with respect to all factors other than financial but there is a spenddown (see ^6500^), the application will be approved in a

spenddown status if there appears to be a likelihood that the spenddown will be met within the 6 month eligibility base period using evidence provided by the client. This is an administrative procedure to meet the application disposition time requirements and to preserve the original application date. However, there is no eligibility until the spenddown is met. See ^1412^ concerning suspension.

Upon certification of eligibility initially or after suspension, a medical identification card may be issued by the regional/local SRS office or the HW Clearinghouse, covering any months for which a card will not be issued automatically. Subsequent medical cards are issued by the fiscal agent.

1406.02 **Denial** - A denial shall be processed to assure that the applicant is provided with his/her denial notice in a timely manner. A notice of denial shall be sent at the time of denial, explaining clearly the reason for the denial.

(1) - Found Ineligible - An application shall be denied if the applicant is found to be ineligible (i.e., excess income, excess resources, etc.) as soon as possible, but no later than 45 days following the date the application was filed. If participation is subsequently desired, such households must file a new application. In no case does the denial of the application abridge that individual's right to reapply at any time.

(2) - Failure to Provide Required Information/Cooperation - An application shall be denied after a period of 10 days from the date of a written request for information, but no later than 45 days from the date of application when the applicant has failed to provide required information or cooperate with eligibility requirements. The applicant must be informed writing of the 10-day standard and the date by which the verification /cooperation must be received.

If the information is subsequently received or the household cooperates within the 45 day application processing time period, the application shall be reactivated and, if eligible, benefits prorated from the date of application. If the information/ cooperation are not received within the above time frames, then the client must re-apply.

(3) - Spenddown - When a spenddown is established for a minor who would otherwise be eligible for Title 21 coverage, eligibility staff must ascertain the likelihood that the

spenddown will be met. In order to make this determination and prevent delaying Title 21 approval, contact with the applicant must be made as quickly as possible. The applicant must be informed of the spenddown amount and given a 10 day notice to respond to the likelihood that the spenddown will be met within the 6 month eligibility base period. If the applicant fails to respond or it does not appear that the spenddown will be met, the application will be denied (or MA case closed for failure to meet the spenddown) and Title 21 coverage will be authorized. In spenddown cases where there is no possibility of Title 21 eligibility, the spenddown is established and the case remains open throughout the base period. At the end of the base period, staff determines if there is a need for further spenddown coverage.

(4) - Another Agency Assumes Responsibility - The agency may dispose of the application if another agency assumes complete responsibility for meeting the applicant's need.

(5) - Cannot be Located - The agency may dispose of the application if the applicant has moved and cannot be located. The agency shall not send a notice of decision.

(6) – Failure to Return Signature Page - If the signature page of an on-line application is not signed and returned to the local SRS office within 10 calendar days, the application will be denied. If it is later returned within 30 days of the date the application was originally submitted, the previously submitted application shall be reinstated and a new application is not required. Assistance shall then be determined from the date the signature page is returned.

1406.03 **Pending** - If a decision cannot be made on an application within the applicable timely processing period because of agency delay, the application shall not be denied. The Case Manager shall notify the applicant(s) that its application is still pending, and what action, it must take to complete the application process and what date the action must be taken or the case will be denied.

1407 **Expedited Medical Service for Pregnant Women Program** - Expedited service shall be provided to eligible applicants for pregnant women who apply for medical assistance. Specific requirements are delineated in the sections that follow.

Expedited Medical Eligibility for Pregnant Women - All pregnant women who apply for medical assistance, shall be initially assessed for expedited medical eligibility. If eligible based on the criteria listed below the pregnant woman shall receive a medical card no later than 10 calendar days from the date of application.

In order to qualify for expedited medical eligibility, the pregnant woman must:

1407.01 - Meet the financial requirements of the poverty level program in accordance with ^2280^; and

1407.02 - Meet all general eligibility requirements as referenced in ^2270^ except for the completion of an SS-5 for those who do not have or cannot provide a Social Security number.

If all of the above criteria are met, the pregnant woman shall be initially approved for expedited medical assistance only within the 10 day time frame. Only the pregnant woman is eligible for expedited medical assistance. A formal determination of eligibility would then be completed based on the normal processing time guidelines for the pregnant woman. If the pregnant woman is not eligible for expedited medical assistance, the formal determination process shall then be initiated.

For purposes of determining expedited medical eligibility, the simplified eligibility concept of ^1320^ shall be used to the greatest extent possible. The information on the application/ redetermination form and statements of the pregnant woman shall be accepted as long as eligibility can be determined from that information. If the information provided is inconsistent or incomplete (e.g., estimate of income not provided) so that eligibility cannot be determined, expedited eligibility shall be postponed until sufficient information is provided. All verifications may be postponed including the pregnancy verifications in order to meet the 10 day processing time. However, such verifications will need to be provided in order to complete the formal determination process.

Expedited medical eligibility status shall not extend beyond two months following the month of application for assistance. If the pregnant woman were later determined ineligible for assistance, the case would be closed allowing for timely and adequate notice. Any resulting overpayments will be subject to recovery.

The continuous eligibility provisions of ^2301^ would not be applicable if the income used to determined expedited eligibility was incorrect and the revised amount actually exceeded the poverty level standard from the beginning.

If the anticipated category of assistance is apparent based on the initial assessment, the case could be opened using the appropriate program. Otherwise the case should be initially opened on a poverty level program.

01410 Case Disposition - Assistance may be suspended for individuals who are temporarily not eligible. It may also be suspended in instances in which it would appear to affect eligibility but there is not enough information to make a final determination. Action to suspend must follow the advance notice requirements of ^1422^.

1411 Provisions Specific to Medical Eligibility - Suspension of medical benefits does not shorten an established medical eligibility base period and a new application is not required to reinstate assistance within the period. Regardless of the procedure used, medical eligibility shall not be suspended without meeting notice requirements related to adverse action. Benefits shall not be suspended for more than 6 months except in rare cases where there is clear documentation that circumstances have changed so that medical eligibility can reasonably be expected within the next 6 month period. If the case is not to be closed, medical eligibility on a medical only case will be suspended. Refer to the KAECSES User Manual for procedures when:

1411.01 - An unmet spenddown is documented at application or due to a change in circumstances. (See ^1406.01^); or

1411.02 - Information needed to determine eligibility is lacking but appears to be forthcoming.

1412 Termination of Assistance - When a recipient no longer meets the eligibility requirements, action to terminate assistance and, taking into account timely and adequate notice in ^1422^, notification requirements related to information obtained through federal computer match in ^1425^ and fiscal processing deadlines. Medical closures will always be effective the last day of a given month. To protect credibility with medical providers, the termination date may not be changed after issuance of a medical card. However, the date of death will be used in the KAECSES system for a deceased individual since there are no eligible services after that date.

01420 Written Notice of Case Action - An applicant or recipient of assistance shall be notified promptly of the action taken on his case. The recipient of assistance shall also be notified of other changes such as an increase or decrease in the spenddown, suspension, or reinstatement after suspension.

1421 Notice of Action - Shall be sent promptly to the applicant or recipient with a copy of any manually prepared notices filed in the case record. When appropriate, a copy must be made available on approvals, suspensions or closure to social services, CSE, or HCBS case manager. Specialized notice forms are required for all cases involving a spenddown, and for all cases in which the medical program will assume at least partial payment for care situations.

Notices shall indicate clearly the action taken, the effective date, and such other information as the situation may require. For all medical approvals, notice must include the beginning and ending dates of the review period. If an application is denied, the applicant shall be informed of the basis for this action. A similar procedure shall be followed for all other changes.

For medical notices the statement shall not, however, indicate:

1422 Timely and Adequate Notice - The agency shall give timely and adequate notice of agency actions to terminate, suspend, or reduce assistance except as provided for in ^1422.01^ regarding dispensing with timely notice and in ^1425^ regarding negative actions resulting from information obtained through federal match data. See ^7420^ for further information on notice provisions for reviews.

1422.01 Adequate Notice - Adequate means a written notice that includes a statement of what action the agency is taking, the reasons for the intended agency action, the specific manual references supporting such action, an explanation of the individual's right to request a fair hearing, and the circumstances under which assistance may be continued if a fair hearing request is made. All notices must be adequate.

1422.02 Timely Notice - Timely means that the notice is mailed at least 10 clear days before the effective date of action. Neither the effective date of action nor the mailing date shall be considered in determining this 10 day period. Closure notices must be mailed no later than the 20th of the month in 31 day months or the 19th of the month in 30 day months to be considered timely

since the effective date of action for closures is always the last day of the month. For other negative actions, specifically benefit decreases or spenddown/liability increases, notices must be mailed no later than the 21st of the month in 31 day months or the 20th in 30 day months as these actions take effect on the 1st day of a month.

1423 Adequate Notice Only - When only adequate notice is required, such notice may be received by the household at the time reduced benefits are received or if benefits are terminated, at the time benefits would have been received if they had not been terminated. The agency is not required to send timely notice but must send adequate notice not later than the date of action when:

1423.01 - The agency denies an application for assistance. However, denials resulting from information obtained through federal match data shall be subject to the provisions of ^1425^.

1423.02 - The agency has factual information confirming the death of a client or of the payee when there is no relative available to serve as new payee.

1423.03 - The agency receives a clear written statement signed by a client indicating that he no longer wishes assistance, or that gives information which requires termination or reduction of assistance, and the client has indicated, in writing, that he understands that this must be the consequence of supplying such information.

1423.04 - The client has been admitted to an institution and further medical assistance will not be provided to that individual.

1423.05 - The client has been placed in a Medicaid approved institution for long term care or begins HCBS and will receive Medicaid payment for the cost of care.

1423.06 - The client's whereabouts are unknown and agency mail directed to him has been returned by the post office indicating no known forwarding address.

1423.07 - A client has been accepted for assistance in a new jurisdiction and that fact has been established by the jurisdiction previously providing assistance.

1423.08 - MA CM child is removed from the home as a result of a judicial determination, or voluntarily placed in foster care by his legal guardian.

1423.09 - Assistance is approved and negative case action such as a closure is incorporated into the initial notice of action to the client. However, negative action resulting from information obtained through federal match data shall be subject to the provisions of ^1425^.

NOTE: Timely and adequate notice must be given for any termination in benefits resulting from information obtained by the consumer or other sources.

1423.10 - A client is disqualified for fraud through a court of appropriate jurisdiction.

1423.11 - A premium requirement is established or increased for a HealthWave case per ^2440^.

1424 Automatic Benefit Adjustments for Classes of Clients - When changes in either state or federal law require automatic adjustment for classes of clients, timely notice of such adjustments shall be given which shall be adequate if it includes a statement of the intended action, the reasons for such intended action, a statement of the specific change in the law requiring such action, and a statement of the circumstances under which a hearing may be obtained and assistance continued.

1425 Notice of Actions Resulting from Federal Match Data - Based on the provisions of the Computer Matching and Privacy Protection Act, no immediate action to suspend, terminate, reduce, or deny assistance in the medical program may be taken as a result of information obtained through federal match data which has not been determined to be accurate and reliable by the federal agency producing the data. When the federal information has not been determined to be accurate and reliable, the individual must be given 30 days from the date the notice of action is received to verify or contest the match data. This means that such notice must be sent at least 35 days prior to the effective date of action for recipients or the date the application is to be processed for applicants.

Federal matches currently affected by these provisions include the SIEVS (IRS and BEER data) match and VA match. It does not include BENDEX, SDX, SAVE information from INS, and third party queries

obtained through SSA as all of these data exchanges are either considered to be accurate and reliable or involve a computer match process between state and federal records. It also does not include Employment Security matches as this is not a direct federal-state match.

If the individual does not respond to the notice, final action based upon the match data can be taken upon expiration of the 35 day notice period and allowing for timely and adequate notice of action. All or part of the 10 day timely notice period may run concurrently with the 35 day notice period. However, all BEERS and IRS-related match data is to be considered as a lead only and not to be used as primary verification or evidence without further independent verification.

If the individual confirms the validity of the information prior to the expiration of the 35 day period, action can be taken immediately allowing for 10 day timely and adequate notice. In addition, for applicants, action can be taken to deny the application without a 35 day notice period, if the individual has already confirmed the match data through verification provided or information which was incorporated on the application form.

If the individual contests the data during the 35 day notice period, no action can be taken until the information is further verified. If the individual cannot provide verification in regard to IRS or BEER data, contact with such sources as the financial institution, employer, etc. will need to be made.

Client cooperation in the verification process will be essential for any action prior to the 35 day notice period. If the client refuses to cooperate and/or contests the information and verification cannot be otherwise obtained, action can be taken on the case following the expiration of the 35 day notice period and allowing for timely and adequate notice of the action.

01500 Fair Hearings -

1501 Request for a Hearing -

A request for a fair hearing is defined as a clear expression, or written, to appeal a decision or final action of any agency or employee of the Division of Health Policy and Finance or the Department of Social and Rehabilitation Services. The Office of Administrative Hearings in the Department of Administration administers the agency's fair hearing program pursuant to the Kansas Administrative Procedure Act (K.S.A. 77-501 et seq.).

The rights, responsibilities, and procedures for fair hearings for other

interested persons are similar to those applicants/recipients as explained in this section except that hearings for other interested persons shall be held in Topeka.

The following persons may request a fair hearing:

1501.01 - Any person who is an applicant, recipient, or other interested person including inmates and taxpayers may request a fair hearing.

1502 Time Period For Requesting A Hearing - The date of request shall be the date the agency received the request.

1502.01 - Unless preempted by federal law, a request for a fair hearing shall be in writing and received by the agency within 33 days from the date the notice of action is mailed. When a request for a fair hearing is received prior to the effective date of action as prescribed in ^1503^, assistance may be continued.

Such request may relate to an applicant's request for assistance, which is denied, or is not acted upon with reasonable promptness, and to any recipient who is aggrieved by any agency action resulting in suspension, discontinuance, or termination of assistance.

1503 Continuation of Benefits - If a written request for a fair hearing is received within 10 days of the date the notice of adverse action is mailed; assistance shall not be suspended, discontinued, or terminated until a decision is rendered after a hearing, unless:

1503.01 - A determination is made at the hearing by the hearing officer that the sole issue is one of state or federal law or regulation, or change in state or federal law and not one of incorrect application of a policy (when appropriate, local SRS staff or HealthWave Clearinghouse staff should raise this issue in the hearing in order for the referee to render a decision).

1503.02 - A change (except the matter under appeal) affecting the recipient's assistance occurs while the fair hearing decision is pending and the recipient fails to request a hearing after notice of the change.

1503.03 - The request for a fair hearing concerns a discontinued

program or service.

1503.04 - The review period expires. The household may reapply and may be determined eligible for a new review period with a benefit amount as determined by the agency.

1503.05 - A mass change affecting the household's eligibility or basis of issuance occurs while the hearing decision is pending.

Assistance shall also be continued at its prior level if the client or agency submits a timely request for review by the State Appeals Committee. See ^1507^.

NOTE: In any case where action was taken without timely notice, if the recipient requests a hearing within 10 days of the mailing of the notice of action, and the agency determines that the action resulted from other than the application of state or federal law or policy or a change in state or federal law, assistance shall be reinstated and continued until a decision is rendered in the matter as set forth above.

1504 Client's Rights Related to a Fair Hearing - The client or the client's representative shall have adequate opportunity to:

1504.01 - Complete a written request for a fair hearing, which may be on the Request for Administrative Hearing form, regarding any agency action. However, a hearing need not be granted if the request concerns only the validity of federal or state law or regulation. In addition, a hearing need not be granted when either state or federal law requires automatic adjustments for classes of recipients unless the reason for an individual appeal is incorrect computation. See ^1503.01^.

1504.02 - Examine the contents of his case file and all documents and records to be used by the agency at the hearing at a reasonable time before the date of the hearing as well as during the hearing. Refer to ^1500^ regarding confidential case file information.

1504.03 - At his option, present his case himself, or with the aid of an authorized representative, and bring witnesses.

1504.04 - Establish all pertinent facts and circumstances and advance

any pertinent arguments without undue interference.

1504.05 - Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

1504.06 - Submit evidence to establish all pertinent facts and circumstances in the case.

1505 Responsibilities of the Local Office and HealthWave Clearinghouse - Every applicant/recipient shall be informed in writing at the time of application and at the time of any subsequent action affecting medical assistance of the right to a fair hearing, the method of obtaining such hearing, and that representation may be by an authorized representative such as legal counsel, relative, friend, or other spokesperson. Information printed on the application/redetermination form and notices of action will provide this information.

Agency hearing procedures shall be uniform, clearly written, and available to any interested party. At a minimum, the procedures shall include time limits for filing requests for appeals, advance notice requirements, hearing timeliness standards, and the rights and responsibilities of persons requesting a hearing. The booklet, Fair Hearing Procedures, shall be used for this purpose.

1505.01 Standard Procedures - The procedures set forth below shall be followed whenever a client makes an inquiry concerning a fair hearing, asks for fair hearing forms, or files a request for a fair hearing.

(1) - The Case Manager or supervisor should find out why the client is questioning the agency action.

(2) - If the client is only disagreeing with a federal or state law or policy, the reason for such policy should be discussed with the client.

(3) - If a client appears to be questioning the application of a federal or state law or policy to his individual situation (incorrect grant computation or use of incorrect facts), an administrative review shall be conducted to determine if the agency action was correct. Upon reconsideration, the agency may amend or change its decision at any time before or during the hearing. The hearing shall not be delayed or canceled because of this preliminary review. If a satisfactory adjustment is reached prior to the hearing, the agency shall submit a written

report to the hearing officer but the appeal shall remain pending until the client submits a signed written statement withdrawing the request for a fair hearing.

(4) - If the client is questioning the decision regarding disability and the decision was made related to an SSI or SSA application for benefits, the client is to be referred to the SSA office to file an appeal. See KEESM 2637.

(5) - If the client is questioning the decision regarding disability and the decision was made by Disability Determination and Referral Services (DDRS) based on an SRS request via the DD-1104 and DD-1105, the appeal will be processed through DDRS as specified in KEESM 2662.1.

1505.02 **Agency Conference** - Local offices and the Clearinghouse shall offer agency conferences to households wishing to contest an adverse agency action. Local office and Clearinghouse staff shall advise households that use of an agency conference is optional and that it shall in no way replace or delay the fair hearing process. The following procedures apply:

(1) - The agency conference may be attended by the Case Manager responsible for the agency action and shall be attended by an EES/CH Supervisor or EES Field Administrator, and by the household and/or its representative. An agency conference may lead to an informal resolution of the dispute. However, a fair hearing shall still be held unless the household makes a written withdrawal of its request for a fair hearing.

Such conferences shall be scheduled within 2 working days of the date the appeal is filed, unless the household requests that it be scheduled later or states that it does not wish to have an agency conference.

1505.03 **Completion of Summary** - Within 15 days after the appellant has filed a request for a fair hearing, the agency shall furnish the appellant and the Office of Administrative Hearings with a summary setting forth the following information:

(1) - Name and address of the appellant;

(2) - a summary statement concerning why the appellant is filing a request for a fair hearing;

(3) - a brief chronological summary of the agency action which led to the appeal and the agency's action after receiving the request for fair hearing;

(4) - a statement of the basis for the agency's decision;

(5) - a citation of the applicable policies relied upon by the agency;

(6) - a copy of the notice which notified the appellant of the decision in question;

(7) - applicable correspondence; and

(8) - the name and title of the person or persons who will represent the agency at the hearing.

(9) - For Appeals of a DDS disability decision
see KEESM 1614.3(9).

If, through an agency conference as discussed in ^1505.02^, the appellant has withdrawn the appeal, completion of the summary is not necessary. The Request for Administrative Hearing form should then be submitted, along with the Notice of Withdrawal of Appeal, to the Office of Administrative Hearings within 7 days of the date of the request for a fair hearing.

1505.04 **Informing the Client of Termination of Assistance** - The agency shall promptly inform the client in writing if assistance is to be terminated pending the fair hearing decision.

1505.05 **Dismissal of Fair Hearings** - Dismissal of Fair Hearings - Kansas statute K.S.A. 75-3306(h) states: "The Department of Social and Rehabilitation Services shall not have jurisdiction to determine the facial validity of a state or federal statute. An administrative law judge from the Office of Administrative Hearings shall not have jurisdiction to determine the facial validity of an agency rule and regulation." So, clients have no right to a fair hearing if they simply disagree with a regulation that results in a loss of eligibility. However, clients may have a hearing if they believe that the agency incorrectly applied such regulation to the client’s individual situation (use of incorrect facts). The issue is whether the client is only challenging the validity of the regulation or really presenting a factual dispute. If there is no dispute between the client and the agency as to the

facts involved, the client’s request for a fair hearing in most instances will be dismissed by the hearing officer before the hearing.

As such, if the client is only disagreeing with a federal or state law or regulation (whether a current regulation or one that is changing) and, after following the procedures set forth in ^1505.01^, wishes to file a request for a fair hearing (or fails to withdraw a request previously filed), the agency should complete a Motion to Dismiss form. (See the Appendix Section of KEESM.) The form is to be submitted to the Office of Administrative Hearings within 10 days of the request for a hearing. A copy of the appropriate Notice of Action and the Request for Administrative Hearing form should be attached to the motion. Do not submit an appeal unless the motion is denied. DHPF or SRS must mail a copy of the Motion to Dismiss to the appellant. The Case Manager should complete the Certificate of Service and sign it. Write the actual mailing date on the certificate, as well as the appellant's name and address. On the Motion to Dismiss, the line "Such action is based on" should reflect the appropriate law or regulation. (Contact DHPF as needed for this information.) For dismissal requests regarding major program changes or cutbacks, specific citations will be provided from the DHPF.

Fair hearings shall also be dismissed if the request is not received within the time periods specified in ^1502^, or the household or its representative fails, without good cause, to appear at the scheduled hearing.

Assistance shall continue as noted in ^1503^ until a decision is rendered concerning the dismissal. If the dismissal request is approved, assistance shall be terminated unless the appellant requests State Appeals Committee review within the 15 days allowed. If the dismissal request is denied, assistance must continue until the presiding officer issues an initial order affirming the agency action, unless there is a State Appeals Committee review request.

1506 Place and Conduct of Fair Hearings - Fair hearings for applicants or recipients shall be held in the Social and Rehabilitation Services' administrative area in which the applicant or recipient resides unless another site has been designated by the hearing officer. At least 10 days prior to the hearing, advance written notice shall be mailed to all parties involved to permit adequate preparation of the case.

The hearing officer may conduct the fair hearing or any prehearing by telephone or other electronic means if each participant in the hearing or prehearing has an opportunity to participate in the entire proceeding while the proceeding is taking place. A party may be granted a face to face hearing or prehearing if good cause can be shown that a fair and impartial hearing or prehearing could not be conducted by telephone or other electronic means.

At a hearing, the hearing officer shall regulate the course of the proceedings. To the extent necessary for full disclosure of all relevant facts and issues, the hearing officer shall provide all parties the opportunity to respond, present evidence and argument, conduct cross-examination and submit rebuttal evidence, except as restricted by a limited grant of intervention or by a prehearing order.

The hearing officer may, and when required by statute shall, give nonparties an opportunity to present oral or written statements. If the hearing officer proposes to consider a statement by a nonparty, the hearing officer shall give all parties an opportunity to challenge or rebut it and, on motion of any party, the hearing officer shall require the statement to be given under oath or affirmation.

A hearing officer need not be bound by technical rules of evidence, but shall give the parties reasonable opportunity to be heard and to present evidence. Evidence need not be excluded solely because it is hearsay.

All testimony of parties and witnesses shall be made under oath or affirmation. Statements of nonparties may be received as evidence.

Any part of the evidence may be received in written form if doing so will expedite the hearing without substantial prejudice to the interests of any party. Documentary evidence may be received in the form of a copy or excerpt. Upon request, parties shall be given an opportunity to compare the copy with the original if available.

The hearing officer may not communicate, directly or indirectly, regarding any issue in the proceeding while the proceeding is pending, with any party or participant, with any person who has a direct or indirect interest in the outcome of the proceeding or with any person who presided at a previous stage of the proceeding, without notice and opportunity for all parties to participate in the communication.

1507 **Fair Hearing Decision and Request for Review** - A fair hearing decision shall be rendered by the hearing officer no later than 90 days after receipt of the request on a Request for Administrative Hearing form or similar document and the decision shall be sent to the client and

the local office or HealthWave Clearinghouse.

The client/respondent shall be informed of his right to have the State Appeals Committee review the decision of the hearing officer and also his right to petition to the District Court. A request to the State Appeals Committee must be made within 18 days of the date of the fair hearing decision. The client/respondent may also have the right to request a re-hearing in order to submit additional information or evidence. This request must also be made within 18 days of the date of the fair hearing decision.

Assistance shall be continued at its prior level if the client or the agency requests a review by the State Appeals Committee. Assistance shall continue until a decision is rendered by the State Appeals Committee.

The decision of the Appeals Committee is final and binding upon the client and the agency on the date of the decision. This is true even if one of the parties should appeal the matter to the District Court. Assistance shall not continue at its prior level following the decision of the State Appeals Committee unless there is a court order to the contrary.

1508 Agency Actions Following Fair Hearing Decisions - The decision of the hearing officer shall be implemented immediately upon receipt (including decisions related to disability) if the decision is favorable to the client and the agency does not intend to request a review by the State Appeals Committee. A report of such action shall be submitted to the Administrative Hearings Section. If the agency requests such a review, the decision shall not be implemented until a final decision by the State Appeals Committee has been rendered. Also, if the decision is unfavorable to the client, the decision shall not be implemented until the 18th day following the date of the mailing of the initial decision to allow the client the opportunity to request a review by the State Appeals Committee. If a request is made within the 18 day period, the decision shall not be implemented.

1508.01 Retroactive Payments - When the hearing decision is favorable to the client, or when the agency decides in favor of the client prior to the hearing, the agency shall promptly make corrective coverage.

1508.02 Recovery of Overpayments - When the hearing decision upholds agency action, any overpayment made during the fair hearing process is subject to recovery, except in situations where the action being appealed is the application of a CSE penalty.

01520 Complaints and Grievances -

1521 Complaint Procedures - A complaint is a verbal or written grievance concerning an agency action or program policy.

1521.01 Complaints Received in the Regional office or CH - Upon receipt of a complaint, the Regional Office or CH Shall:

(1) - Review the situation and determine if corrective action is indicated. The determination should be made by the EES/CH Supervisor or EES Field Administrator after consulting with the Case Manager.

(2) - Explain the action or policy to the complainant in writing or verbally. If corrective action is necessary, it should be initiated immediately. If corrective action is not indicated, inform the complainant of his right to request a fair hearing and the request procedure.

1521.02 Complaints Received in Central Office - Complaints received in central office will be referred to DHPF for a response. If the response requires local input, a telephone call or e-mail message outlining the nature of the complaint will be made to the EES Field Administrator/Clearinghouse Administrator or designee. This person will review the case and determine the appropriateness of the agency's action. If the agency is in error, the EES Field Administrator/Clearinghouse administrator will mandate that corrective action be initiated immediately.

Once the determination is completed, the EES Field Administrator/Clearinghouse administrator or designee will telephone or e-mail DHPF and provide details of the agency's actions as well as any corrective measures taken. DHPF will then answer the verbal or written complaint. If the EES Field Administrator/Clearinghouse administrator wishes to respond to a telephone complaint directly, DHPF will notify the complainant to expect a telephone call from the EES Field Administrator/Clearinghouse administrator or designee within a pre-determined time period.

Complaints filed through the above system shall not include complaints alleging discrimination. Refer to ^1530^ for discussion of Civil Rights complaints. This system shall also not include complaints that should be pursued through the fair

hearing process.

01530 Civil Rights Complaints - Kansas shall maintain a system to ensure that no person in Kansas shall, on the grounds of race, color, national origin, gender, age, sex, disability, political belief, religion, sexual orientation, marital or family status, be excluded from participation in, or be denied the benefits of any Family Medical Program, or be otherwise subjected to discrimination. This applies to all Family Medical programs.

1530.01 - Public Notification, Data Collection, Maintenance, and Reporting

(1) - All applicants and participants shall be informed of the following at the time of the initial application and at each subsequent review:

(a) Rights and responsibilities;

(b) DHPF and SRS's policy of nondiscrimination;

(c) The steps necessary for participation;

(d) Procedures for filing a complaint through the local SRS office, DHPF Central Office, the Civil Rights/EEO Section.

(e) Procedures for filing for a fair hearing.

(2) - The Case Manager shall encourage the responsible person completing the application to complete all questions regarding race or identity on the application. The applicant shall be informed that the information will be used for statistical purposes and will have no effect on his/her eligibility. However, if the applicant fails to provide this information, the Case Manager shall complete the questions by observation if possible.

01600 General Information about Other Programs and Miscellaneous -

1601 Case Records - Case records are required for all assistance cases and are to be separate from social service records. The Family Medical Program record shall include required forms to establish eligibility for assistance and additional information and decisions reached regarding eligibility, the amount of assistance, notices to the client, and authorization forms. Local EES/CH supervisors shall provide training for Case Managers in preparing adequate records and in knowing how

and what information to obtain to establish eligibility, determine amount of assistance, and prepare adequate notices.

1601.01 Order of Material in the Family Medical Case Records - For the purpose of uniformity and convenience in use, the material contained in the case folder shall be organized in like groups and fastened together chronologically with the most recent material on top.

1601.02 Correspondence - Correspondence which is a substitute for personal interviews plays an important part in the functioning of the agency and for this reason as much care is needed in planning correspondence as is used in the preparation for a personal interview. Notices affecting the eligibility shall become a permanent part of the agency's record.

(1) - Content of Notices - All notices should contain sufficient information to make clear their purpose, the information desired, and how the information is to be used. The wording should be clear, direct, and adequate to cover the subject. Care should be taken to avoid misunderstanding or misinterpretation.

(2) - Filing - Letters from clients are to be retained if they contain significant material. If only an item or two is significant, this information may be recorded and the letter destroyed.

Letters, newspaper clippings, and other material, when not of standard size, should be fastened to full-sized sheets of paper for case filing. They should be dated and properly identified.

1602 Disposition of Obsolete Case Record Material - Destroy any material which is older than 36 months and is not currently in effect on active cases with the following exceptions:

1602.01 - The last application which opened the case;

1602.02 - For AABD cases converted to SSI (whether open for medical or not), the application and budget in effect for December 1973 must be retained indefinitely;

1602.03 - Retain indefinitely all documentation needed to establish current eligibility and payment such as the number of months on assistance, felony drug convictions, progressive penalty

occurrences, etc.;

1602.04 - Retain indefinitely the PA-3120.4 (Welfare Enumeration) or screen print of SSDO and copies of all documents used for enumeration purposes.

1602.05 - Retain indefinitely all material pertaining to unrecovered overpayments, including all documentation for the amount and cause of the overpayment.

1602.06 - Retain indefinitely all material pertaining to verification of the immigration status of aliens.

1602.07 - Retain indefinitely all materials pertaining to documentation of common-law marriage or paternity.

Closed medical cases may be destroyed after they have been closed for 36 months except for (1) all material pertaining to unrecovered overpayments, or (2) cases that have a designated period of ineligibility which exceeds the retention period (e.g., first-time conviction of fraud, etc.)

1603 Voter Registration - The National Voter Registration Act of 1995 requires voter registration to be available in public assistance offices. The Act also requires that anyone applying for or receiving public assistance, including TAF, GA, Food Assistance, Medicaid, Child Care, and LIEAP, be offered the opportunity to register to vote at the time of initial application, each eligibility review, and each report of a change of address. Each individual must be informed of this registration service and offered assistance in completing the voter registration form or declining the registration activity. The ES-3100, Application for Cash, Medical, Child Care, and Food Stamp Benefits, offers everyone the opportunity to register to vote or to decline to register. Completion of the voter registration page of the ES-3100 is not a condition of eligibility for assistance. If an individual does not sign or complete this page of the application, it is considered a declination of voter registration and has no bearing on case processing or eligibility. Those applying on-line are offered the opportunity to link to the Secretary of State's voter registration site. Change of address forms developed by local offices must include the same voter registration and declination information as is included in the ES-3100. SRS staff taking a report of a change of address or name change by telephone or in person should inform the individual that a change of address or name requires new voter registration and ask the individual if they wish to register to vote. All

those who answer "yes" are to be handed or mailed a voter registration application. The individual's response to the offer to register to vote is to be recorded on a declination form. Local offices must keep all declination forms for at least two years. See KEESM Appendix Item #88 for a copy of the Voter Registration Application.

1604 **Estate Recovery** - The estate recovery program has been established as a means to recover medical care costs from the estates and property of certain medical assistance recipients. See KEESM 1725

01700 **Delivery of Medical Cards** - All medical cards issued must be delivered by mail to the address of the payee unless otherwise requested. If the payee requests a different mode of delivery, the agency shall consider the appropriateness of the request. When deemed appropriate the agency may use other modes of delivery including P.O. Boxes, General Deliveries, addresses of friends or relatives, or the address of the agency when it is necessary to hand deliver the warrant or medical card to the client, particularly for situations involving a homeless client. No materials may be included in the envelope containing the medical card except those directly related to the administration of the welfare program.

Procedures for temporarily detaining or redirecting benefits through "Hold" processes can be found in the KAECSES User Manual and the General Services Manual.

02000: **General Eligibility Requirements** -

02010 **Act in Own Behalf** - The client must be legally capable of acting in his or her own behalf.

Legally Incapacitated Persons - Legally incapacitated persons are not eligible to receive assistance unless such assistance is applied for by a guardian or conservator. For medical applications taken on behalf of adults who have not been determined as legally incapacitated, the spouse, conservator, guardian, personal representative, (as defined in KEESM 1522), legal custodian, person with a durable power of attorney, or representative payee for Social Security benefits shall be regarded as having the authority to act and make application in the adult's behalf. If some other person is making the application, the signed written consent of the person for whom they are applying must be obtained. The medical representative authorization on the back of the application/redetermination form shall be used for this purpose and must be signed by the applicant and at least one witness. In rare instances where obtaining written consent is not possible, the application shall be accepted and an effort should be made to have a guardian or conservator appointed for the

individual by referring the matter to Social Services. For example, an individual may have been involved in a recent auto accident and is in a coma. Rather than deny or delay assistance because an appropriate person is not available to apply for the individual or is unable to get the individual's written consent, the application can be taken and eligibility determined while efforts are made to appoint a guardian or conservator if appropriate. Where someone other than a spouse, guardian, conservator, personal representative, legal custodian, durable power of attorney, or representative payee for Social Security benefits has been given authority to act in the applicant's behalf, all notices must still be sent to the applicant/recipient. A copy of the notices can be sent to the authorized medical representative as well.

2011 Minors - Minors who are unable to act in their own behalf are not eligible to receive assistance unless such assistance is applied for by an adult household member. In addition for medical assistance purposes, an application for a minor can also be made by a representative payee for Social Security benefits or a responsible adult with whom a child resides as a result of an approved social service plan. An individual who meets one of the above criteria to apply on behalf of a child may also request prior medical coverage for the child. This is true even if the individual did not meet the criteria or was not living with the child during the prior medical period. However, eligibility shall be determined based upon the child's situation in the month (see ^3100^ - Assistance Planning).

2011.01 - Minors can act in their own behalf and receive assistance under the following circumstances:

(1) - The minor is determined to be emancipated. An emancipated minor is a person who is:

(a) Age 16 or 17 and is or has been married; or

(b) Under the age of 18 and who has had the rights of majority conferred upon him or her by court action; or

(2) - The minor is unemancipated (i.e., does not meet the criteria in (1)(a) or (b) above), there is no adult or emancipated minor exercising parental control over the child, and one of the following circumstances exist:

(a)The parents of the minor are institutionalized per KEESM 4140 or the minor has no parent who is living or whose whereabouts is known, and there is no other caretaker who is willing to assume parental control of the minor; or

(b)The health and safety of the minor has or would be jeopardized by remaining in the household with the minor's parents or other caretakers. Such status must be documented by an independent source such as social services, law enforcement, religious
authorities or a battered person's shelter.

If local arrangements are made between Health Care Policy/Medical Policy and Children and Family Services (CFS), a referral may be made to CFS for assistance in determining the status of the minor's parents or other caretakers and any health and safety issues that would exist in such living arrangements. The determination of a minor's ability to act in own behalf under this provision must be approved by the EES Field Administrator or his or her designee.

The determination must be documented in the case record. Minors able to act in their own behalf are eligible for FFP medical benefits and can qualify under any medical program (e.g., Medicaid poverty level or HealthWave).

(3) – The minor is placed into independent living by SRS (if the minor’s needs are being met by CFS or a foster care contractor, the minor may only apply on behalf or his/her child.)

(4) – The minor enters an approved transitional living program, such as MINK.

(5) – Anyone receiving cash assistance through the State’s TAF program is automatically eligible for Caretaker Medical assistance. See ^2222.02^. If the EES Program Administrator in the Regional Office determines a minor is allowed to act in their own behalf for the TAF program, that minor will also be eligible for Caretaker Medical assistance on their own case number.

Eligibility workers in the Regional Offices are responsible for approving the cash application and corresponding Caretaker Medical coverage. The worker taking the action will document in the case log and indicate on the INDA screen, for the medical case, that the minor was allowed to apply on their own behalf for TAF based on KEESM 2112. Once all of the casework is completed, the case is to be transferred to the HealthWave Clearinghouse for case maintenance.

If the minor is already receiving medical assistance, the

eligibility worker in the Regional Office coordinates with the Clearinghouse to end participation on the open case before establishing medical assistance on the minor's own case number.

The minor, acting on their own behalf as a result of the new TAF rule, will receive twelve-months of continuous eligibility. Continuous Eligibility applies even if the minor leaves the adult-supervised group living arrangement and the EES Program Administrator determines they are no longer able to act in their own behalf for the TAF program.

At the next scheduled medical review, the minor's ability to apply on their own behalf is to be reviewed. If the minor has left the adult-supervised group living arrangement and is no longer receiving TAF assistance on their own behalf, they are not automatically eligible for Caretaker Medical under this provision. The minor must be able to act in their own behalf in accordance with the provisions outlined in ^2011.02^, in order to continue receiving medical assistance on their own case.

02020 Cooperation -

2021 Cooperation - The client must cooperate with all program requirements. In addition, the client (including medical purposes, an ineligible caretaker) shall cooperate with the agency in the establishment of eligibility including providing necessary information, reporting changes , as required, cooperating in the application process, cooperating in quality assurance reviews, and, for medical purposes, cooperating in obtaining resources.

2021.01 Supplying Information - The client (or ineligible caretaker) shall supply information essential to the establishment of eligibility; give written permission on prescribed forms for release of information regarding resources when needed; and report changes in circumstances in accordance with ^7100^, ^7120^, and ^7200^ as appropriate.

Failure to provide information necessary to determine eligibility shall result in ineligibility. A case which has been closed for failure to provide information is to be reinstated when the required information is provided by the end of the month following the effective date of closure and all other eligibility requirements are met.

2021.02 Application and Review Process - To determine eligibility, the application form must be completed and signed, certain information on the application must be verified. If denied or terminated for refusal to cooperate, the client may reapply but shall not be determined eligible until he or she cooperates.

The client shall also be determined ineligible if he or she refuses to cooperate in any subsequent review of its eligibility, including reviews generated by reported changes and recertification. For medical, the formal review requirement does not apply to pregnant women and children under the age of 1 who have continuous eligibility under the Medicaid program or are eligible under the SI program.

2021.03 Potential Resources - For medical purposes, a client shall cooperate with the agency to obtain potential resources. The client is required to take action to:

(1) obtain any resources due such client with respect to whom assistance is claimed; and

(2) obtain any income due such client with respect to whom assistance is claimed, except for MA CM; and

(3) identify and provide information to assist the agency in pursuing any third party who may be liable to pay for medical services under the medical programs.

2022 Requirements - The client is required to take any necessary action to acquire potential resources. In many instances, legal action may be necessary. In general, any source must be considered. It is the responsibility of the client to demonstrate all required actions have been taken to make the resource available. The special situations listed below are applicable:

2022.01 - The client must cooperate with the Medical Subrogation Unit as well as cooperate with the requirements of the Health Insurance Premium Payment System (HIPPS) including enrollment in the employer health insurance plan if cost effective. (See ^2540^.)

2022.02 - A pregnant woman is not required to pursue unemployment compensation (UC) for medical programs. Cooperation is required when the postpartum period as defined in ^2302^ expires.

2022.03 - Persons may not be rendered ineligible for failure to apply for or receive SSI benefits.

2022.04 - Medical assistance recipients who are or have been married are expected to fully pursue any spousal elective share rights when the current or former spouse dies. Under Kansas law, a spouse is entitled to a portion of the augmented estate (generally any estate less the homestead). If all resources do not properly pass onto the surviving spouse at the time death, the surviving spouse may file a probate claim to obtain the allowed spousal share. Failure to pursue any spousal elective share rights shall result in ineligibility. Legal staff in the Estate Recovery Unit (ERU) are available to assist with technical details regarding potential actions. All cases involving potential spousal elective share issues shall be referred to ERU. When spousal rights have been forfeited a transfer of property penalty may be applied (see KEESM 5722).

2023 **Failure to Comply** - Failure to meet these requirements without good cause shall: For medical assistance, render the client ineligible for assistance. However, minor children will not be impacted by a caretaker's failure to meet these requirements on behalf of himself or the minor. If the client is cooperating in obtaining the identified potential resource, assistance shall continue.

02030 **Social Security Numbers** -

2031 **Social Security Numbers (Not Applicable to TransMed)** - As a condition of eligibility, a Social Security number must be provided for each applicant (with the exception of newborns - see ^2032^), or an application filed for one before assistance is approved.

For those individuals who provide an SSN prior to approval or during any contact, the specialist shall record the SSN and verify it according to ^2031.01^ (1). For those individuals required to provide an SSN who do not have one, who do not know if they have one, or who are unable to find their SSN, or for whom the SSN provided appears questionable, an application for a Social Security number must be completed. The SSN application must be made at the local SSA office and verification of that application from SSA must be provided before approval. An SSN may be applied for on a newborn child through the SSA's Enumeration at Birth process. If individuals have more than one number, all numbers shall be provided. The specialist shall explain to clients that refusal or

failure without good cause to provide or apply for an SSN will result in exclusion of the individual for whom an SSN is not provided. The individual that has applied for an SSN shall be allowed to participate pending receipt of an SSN.

2031.01 **Verification of SSN** - (1) - The Social Security number(s) reported by the client shall be verified by an automated match with the Social Security Administration. SSN's annotated with a "V" on the Client Profile (CLPR) screen are considered verified. In addition, either BENDEX or SDX will provide a verified SSN for those individuals receiving either SSA or SSI benefits.

(2) - If the individual who has reported a Social Security number has no Social Security card or other official document containing the SSN and the number has not been verified as described in item (1), an application for a replacement Social Security card must be requested. The person should be referred to the appropriate SSA office via the SSN-1 form (see KAECSES Miscellaneous Forms Section). See ^2036^. Proof from SSA that the individual has applied for the replacement Social Security card shall meet the SSN verification provision pending receipt of further documentation.

(3) - A permanent record of SSN verification shall be maintained in the case file by screen-printing SSDO or CAP 2 that lists all clients or household members. If applicable, a copy of the SSN-1 or any Enumeration at Birth documents should be included. A verified SSN shall be reverified only if the identity of the individual or the SSN becomes questionable.

2032 **Participation Without an SSN** - If any client is unable to provide an SSN, that individual must apply for one prior to approval. The individual must apply for the required SSN at the Social Security Office and verification of application for the number is required. The individual who is unable to provide an SSN, but has applied for one, may receive assistance pending receipt of the required Social Security number. When the client submits proof of application for an SSN, the individual may participate throughout the duration of the review period. (This includes SSN's applied for through the SSA's Enumeration at Birth process.) If the SSN has not been reported by the time of the next review, it should be requested at that time. If the client has the SSN, but fails or refuses to provide it, the individual is ineligible per ^2034^. If the client claims they did not receive an SSN, or that they received the number, but have subsequently lost it, they must begin the process again by applying for a

replacement card at the district SSA office. Once the client reapplies for a number and provides documentation, they may receive assistance until the next review.

If proof of application for an SSN for a newborn cannot be provided, the SSN or proof of application must be provided at the next review or within 6 months following the month the child is born, whichever is later. If an SSN or proof of application for an SSN cannot be provided at the next review or within 6 months following the baby's birth, the State agency shall determine if the good cause provisions of ^2033^ are applicable.

NOTE: Based on SSA's Enumeration at Birth process, a parent can apply for an SSN for a newborn child through the process of initiating a birth certificate at the hospital. If he or she does so, documentation that an SSN has been applied for can be acquired from the hospital in one of the two ways. For hospitals submitting birth registration information to the Kansas Office of Vital Statistics electronically (through the Electronic Birth Certificates or EBC process), a letter on the hospital stationery is acceptable. This letter must be titled "Birth Confirmation Letter," contain information about the birth and a statement confirming the SSN application, and be signed and dated by an authorized hospital official. For hospitals which do not use the electronic process, a copy of form SSA-2853 which is given to the parent is acceptable. The SSA-2853 form must contain the name of the newborn as well as the date and signature of an authorized hospital official to be considered valid documentation. A copy of the letter or form is to be included in the case file. If the letter or form is not available, a copy of the child's certified birth certificate showing that the Enumeration process was elected is also acceptable documentation.

2033 Good Cause for Participation Without an SSN - The client who establishes good cause for failure to apply for an SSN shall be allowed to receive assistance for 1 month in addition to the month of application. For benefits to continue past these 2 months, good cause for failure to apply must be shown and documented on a monthly basis.

In determining if good cause exists for failure to comply with the requirement to apply for or provide an SSN, the specialist shall consider information from the individual, SSA, and any other appropriate sources. Documentary evidence or collateral information that the individual has applied for an SSN or made every effort to supply the necessary documents to complete an application for an SSN shall be considered good cause for not complying timely with this requirement. Good cause does not include delays due to illness, lack of transportation, or temporary absences because SSA makes provisions for mailing

applications in lieu of applying in person. If the individual can show good cause why an application for an SSN has not been completed in a timely manner, that person shall be eligible for assistance for 1 month in addition to the month of application. Good cause for failure to apply must be shown monthly after the initial 2 months for such an individual to continue to participate. Good cause must be documented to support the decision to allow the individual to receive assistance pending application for an SSN.

2034 **Refusal or Failure to Provide or Apply for SSN** - An individual who has without good cause refused or failed to provide an SSN or to apply for one shall be ineligible for assistance. The eligibility and amount of benefits for any remaining family or household members shall be determined. The income of the excluded individual shall be considered.

The individual excluded for failure or refusal to provide or to apply for an SSN may become eligible upon providing the agency with an SSN or proof of application for the required number. The report of this number or proof of application for such number shall be treated as a reported change and benefits affected as outlined in ^7212^.

2035 **Use of SSN** - The agency is authorized to use SSN's in the administration of the medical program. The SSN shall be used in accessing KSES records of wages and benefits. To the extent determined by Health and Human Services, the agency shall have access to information regarding individual clients who receive benefits under Titles II, XVI, and XVIII of the Social Security Act to determine eligibility to receive assistance and the amount of assistance or to verify information related to the benefits of these clients. The specialist should use the BENDEX and SDX to the greatest extent possible. Social Security numbers also should be used to prevent duplicate participation and to determine the accuracy and/or reliability of information given by the client or household.

2036 **Referral Procedure for Applying for an SSN** - The following referral procedure shall be used for persons who must apply for an SSN.

2036.01 - Refer all persons needing to apply for an original or replacement SSN per ^2031^ to the appropriate local SSA office via the SSN-1 form. (See Miscellaneous Forms Section.) The top half of this form is to be completed by staff including the case name and case number and the name and address of the office and Case Manager making the referral. Up to 4 case members needing to apply for a number can be referred on one form.

The state welfare ID number is to be indicated on the form so that the SSN will be entered in the KAECSES system automatically once assigned. That ID number must be listed in the following sequence:

(1) - First 2 digits are the State Bendex Code, 17.

(2) - The next 10 digits are the client ID number from KAECSES.

(3) - List all of the digits as one continuous number. Example: 1700112345678.

2036.02 - The client is to take the referral form along with the necessary supporting documentation to the SSA office when he or she applies. Sufficient time should be given for the client to accomplish this.

2036.03 - Once the client has applied, SSA will return the referral indicating the action taken. If the application process was completed, the client meets the SSN requirement and can be approved for assistance. If the individual could not, without good cause, complete the process, he or she is ineligible for assistance per ^2034^.

2036.04 - A copy of the completed referral form is to be kept in the case file as proof of application for an SSN.

2036.05 - If the person is unable to apply in person at the SSA office (e.g., transportation problems, accessibility to office, physical limitations, etc.) this same procedure can be used on a mail-in-basis. In these instances, staff would provide an SS-5 for the client to complete along with a referral form. The SS-5, referral form, and necessary documentation would then need to be mailed by the client to the appropriate district SSA office. (See KEESM Appendix for SS-5 instructions and SSA addresses.)

The original documents (e.g., birth certificate, other identification, etc.) must be sent to support the application. Photocopies are not acceptable.

Staff should inform the client of the necessary documentation needed and assist him or her in completing the SS-5.

Once the application is received, SSA will return the referral form as with the walk-in procedure.

In certain instances, a client may have previously applied for a number prior to the request for assistance. A receipt from SSA acknowledging the application is still acceptable proof for meeting the SSN requirement.

2037 Entering SSN's on KAECSES - An SSN initially supplied by a client shall be entered on SSDO even if it has not been verified. If the number is not initially known, the date on the SSN-1 shall be entered.

If the number supplied by the client is later determined to be incorrect through either the BENDEX verification process or the SRS validation process, the SSDO screen shall be updated to reflect the proper number or, if the proper number is unknown, the date on the SSN-1 shall be entered.

02040 Citizenship and Alien Status -

2041 - Eligibility for assistance shall be limited to those individuals who are citizens or who meet qualified non-citizen status as specified in ^2043^.

Non-citizens who are not described in ^2043^, including persons not lawfully admitted to the United States and persons admitted for temporary purposes, shall not be eligible for benefits, except for emergency medical benefits as described in KEESM 2691. This is true even though the non-citizen may be receiving other government benefits such as Medicare. Other examples of non-eligible persons include those who are granted stays of deportation, persons admitted under the Family Unity provision, foreign visitors, tourists, diplomats, or students who enter the United States temporarily with no intention of abandoning their residence in a foreign country. A non-citizen who enters the United States for a limited period of time and subsequently decides to remain in the United States must go back to USCIS and obtain appropriate documentation before his or her eligibility can be established.

At the time of application, the client who signs the application form certifies under penalty of perjury the truth of the information concerning citizenship and non-citizen status of all household members for whom assistance is requested.

NOTE: For cases in which assistance is provided on behalf of a child, such as HealthWave, only the citizenship or non-citizen status of the child who is the primary beneficiary is relevant for eligibility purposes.

2042 **Citizenship** - Citizens of the United States of America include persons born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, Swains Island, and the Northern Mariana Islands. Persons born in the Panama Canal Zone from 1904 to October 1, 1979 received citizenship at birth if one or both parents were a U.S. citizen. In addition, based on the provisions of the Child Citizenship Act, children born outside of the United States who are under 18, admitted to the U.S. as a lawful permanent resident, and in the legal and physical custody of a citizen parent meet citizenship criteria automatically.

2043 **Qualified Non-Citizen Status for the Medical Programs** - Eligibility for medical (including Medicaid and HealthWave) benefits is limited to the following groups of qualifying non-citizens who also meet state residency requirements. Documentation requirements are specified in KEESM appendix item A-1, Non-Citizen Qualification Chart. The 5 year ban on receipt of assistance described in ^2045^ does NOT apply to the following non-citizens.

2044 **Eligible Non-Citizens** - The following non-citizens are eligible for medical benefits.

2044.01 - Refugees admitted under 207 of the Immigration and Nationality Act (INA);

2044.02 - Asylees granted asylum under 208 of the INA;

2044.03 - Aliens whose deportation has been withheld under Section 243 (h) of the INA;

2044.04 - Cuban or Haitian entrants as defined in section 501 of the Refugee Education Assistance Act of 1980;

2044.05 - Persons admitted as an Amerasian Immigrant pursuant to section 584 of the Foreign Operational Export Financing, and Related Programs Appropriations Act of 1988;

2044.06 - Persons who are honorably discharged veterans or are on active duty in the United States armed forces. In addition, the spouse and/or dependent children of such persons would also be deemed as meeting qualified non-citizen status. (Includes individuals who served in the Philippine Commonwealth Army

during WW II or as Philippine Scouts following the war. This change is pursuant to the Balanced Budget Act of 1997.);

2044.07 - Persons who have obtained lawful permanent residence status and who entered the U.S. on or before August 22, 1996. This includes persons who did not obtain lawful permanent resident status until after August 22, 1996 (Also see ^2047^.);

2044.08 - Persons granted parole or conditional entry status and who entered the U.S. on or before August 22, 1996. This includes persons who did not obtain such status until after August 22, 1996; and

2044.09 - Persons who do not meet one of the other qualifying statuses, but who have been battered or subject to extreme cruelty by a U.S. citizen or lawful permanent resident spouse or parent and who entered the U.S. on or before August 22, 1996. Such persons must have a pending or approved Violence Against Women Act (VAWA) case or family-based petition before USCIS. This also includes the person's children who have also been battered or subject to extreme cruelty.

2044.10 - For medical benefits only, American Indians born in Canada to whom the provisions of Section 289 of the USCIS apply and members of an Indian Tribe as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act. This provision is intended to cover Native Americans who are entitled to cross the U.S. border into Canada. This includes among others, the St. Regis Band of the Mohawk in New York State, the Micmac in Maine, and the Abanaki in Vermont.

2044.11 - Non-citizens who are certified victims of severe forms of trafficking, and some family members, who are admitted to the U.S. as refugees under section 207 of the INA. See KEESM 2144

2045 Non-Citizens Who Qualify After 5 Years From the Date of Entry or the Date Status Was Granted - The following non-citizens who entered the U.S. after August 22, 1996 qualify for medical benefits (if otherwise eligible) after they have been in the country for 5 years from the date of entry, or have had the listed statuses for five years.

If they have not been in the country for five years from date of entry, or had one of the listed statuses for 5 years, they do not meet non-citizen

criteria and are ineligible.

2045.01 - Persons lawfully admitted for permanent residence;

2045.02 - Persons granted parole or conditional entry status;

2045.03 - Persons who do not meet one of the statuses listed in (a) or (b) above, but who have been battered or subject to extreme cruelty by a U.S. citizen or lawful permanent resident spouse or parent with pending or approved Violence Against Women Act (VAWA) cases or family-based petitions before USCIS. This also includes the person's children who have also been battered or subject to extreme cruelty.

2046 Documentation of Citizenship - United States citizenship shall be documented and verified only when a household's statement concerning a member is questionable. Acceptable forms of documentation are:

2046.01 - Birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/31/41), Guam, the U.S. Virgin Islands (on or after 1/17/17), American Samoa, Swain's Island, Panama Canal Zone (from 1904 to 101/1/79), or the Northern Mariana Islands (with the exception of persons born to foreign diplomats residing in the U.S.);

This includes report of birth abroad of a U.S. citizen per form FS-240 (issued by the Department of State to U.S. citizens), Certificates of Birth per form FS-545 (issued by a foreign service post), and Certifications of Report of Birth per form DS-1350 (copies available from the Department of State).

2046.02 - Religious records;

2046.03 - Voter registration cards;

2046.04 - Certificates of citizenship or naturalization provided by USCIS, such as Identification Cards for Use of Resident Citizens in the U.S. (USCIS Form I-79 or USCIS Form I-97);

2046.05 - U.S. passports; and

2046.06 - Receipt of public assistance if verification of citizenship was

obtained for that household.

If the above forms of documentation cannot be obtained and the individual can provide a reasonable explanation as to why documentation is not available, the agency shall accept a signed statement from someone who is a U.S. citizen which declares, under penalty of perjury, that the person in question is a U.S. citizen.

The signed statement shall contain a warning of the penalties for helping someone commit fraud, such as: "If you intentionally give false information to help this person get assistance, you may be fined, imprisoned, or both."

The individual whose citizenship is being questioned shall be ineligible to receive assistance until proof of U.S. citizenship is obtained. The individual disqualified pending documentation and verification of questionable citizenship will have his or her income and all of his or her resources considered available to any remaining family or household members as set forth in KEESM 4113.

2047 Documentation of Legal Status - Applicants/recipients who are identified as non-citizens on their application shall be required to document and verify their non-citizens status. The agency shall determine, from documentation obtained, if the person is a non-citizen who may be eligible to receive assistance. Only those non-citizens who are residents and meet one of the categories of qualifying non-citizens status described in ^2044^ may participate.

For the categories listed in ^2044^, the person may also present other documents which indicate the person's immigration status and which the agency may determine are reasonable evidence of immigration status. For persons who can qualify based on a date of entry on or before August 22, 1996, documentation such as employment or school records can be used to demonstrate that the person was in the country if they did not have legal status or documentation during that time period. Also refer to the status and documentation on the chart and the Guidance on Noncitizen Verification in the KEESM Alien Information Appendix.

2047.01 Documentation Not Clear - If the appropriate USCIS form does not clearly indicate eligible or ineligible status, the agency is responsible for offering to contact USCIS. The agency does not need to offer to contact USCIS on the non-citizen's behalf when the person does not provide an USCIS document.

2047.02 Non-citizens Unable to Provide Documentation - If the alien is unable to provide any documentation of their status, the agency shall advise the person to contact the nearest USCIS office for verification. (Also see instructions in SAVE User Manual.) In these situations, the agency has no responsibility to offer to contact USCIS on the non-citizen's behalf.

While awaiting acceptable documentation, the person whose status is questionable shall be ineligible but the eligibility of the remaining members (if any) shall be determined in accordance with the procedures listed in KEESM 4113. If the non-citizen does not wish to contact USCIS, the family or household shall be given the option of withdrawing its application or receiving assistance without that member.

2047.03 Documentation Obtained Later - If documentation of qualifying status is received at a later date, the specialist shall act on the information as a reported change in accordance with timeliness standards for these changes. See ^7212^ as appropriate.

2047.04 Verification of Alien Status through SAVE - The immigration status of all alien clients must be verified through the Systematic Alien Verification for Entitlements (SAVE) program, which is operated by the Department of Homeland Security (DHS). Detailed instructions on primary and secondary verification procedures are contained in the SAVE User Manual. (See KEESM Appendix A-10) No action to deny, reduce, or terminate benefits may be taken based solely on information obtained from DHS through the SAVE primary verification system.

NOTE: Secondary verification should be requested when the person's entrance date is in question. For persons adjusting status to legal permanent resident, the primary web-based verification system will communicate the date of adjustment rather than the original date of entrance. The secondary system will always provide the original date of entrance.

The results of SAVE verification queries shall be recorded on the SAVE Verification and Cost Avoidance Report (IM-3120.6) which must be retained indefinitely in the case record along with copies of the immigration status documentation provided by the alien. In addition, in response to a secondary

verification request, DHS will attach a copy of a Cost Avoidance Report to the DHS (Form G-845). This report is to be completed and returned to DHS as soon after receipt as possible.

02050 Residence -

2051 Residence - A client must be a resident of the state.

For all medical programs, a resident is one who is living in the state voluntarily and not for a temporary purpose (i.e., with no intention of leaving). Temporary absence from the state, with subsequent returns to the state, or intent to return when the purpose of the absence has been accomplished shall not interrupt continuity of residence. See also ^02140^ regarding temporary absence of children or parents. In addition, individuals who continue to receive a Kansas state supplementary payment while living out-of-state are regarded as Kansas residents.

For Medical programs, residence can be established for persons who are living in the state with a job commitment or who are seeking employment in the state, including temporary stays. This would include migrant workers (both farm and construction) and their family members living with them in the state.

Residence is retained until abandoned or established in another state. When a client notifies the agency of a move to another state with the intent to reside there, the client must be informed in writing that assistance is being discontinued giving timely and adequate notice.

2052 Duplicate Benefits - Residence can be established in a month regardless of whether the person has received benefits from another state in that month.

Persons who move from another state can receive medical benefits in Kansas in the month he or she moves from that state. For medical, the person must be otherwise eligible for Medicaid (including being otherwise eligible for MA/CM except for the prohibition around duplicate payments) or HealthWave.

2053 Institutionalization - For medical assistance, the following criteria apply to persons who are institutionalized:

2053.01 - An individual who is placed by a state agency into an out-of-

state institution retains residence in the state making the placement. Thus, individuals who are placed in care facilities outside of Kansas by SRS retain their Kansas residence.

Providing basic information to individuals about another state's Medicaid program or about the availability of health care services and facilities in another state does not constitute a placement action. This would also include assisting an individual in locating an institution in another state provided the individual was capable of intent and independently decided to move.

2053.02 - For individuals who become incapable of intent before the age of 21 or who are under the age of 21, the state of residence is the state in which their parents or legal guardian reside for applicants or in which they did reside at the time of institutional placement for recipients. If the parents live in different states, the state of residence of the parent making application shall be applicable.

Individuals are considered incapable of intent if: their IQ is 49 or less; or they have a mental age of 7 or less based on reliable tests; or they are judged legally incompetent; or there is medical and social documentation to support a finding that they are incapable of intent.

2053.03 - For individuals who become incapable of intent on or after age 21, the state of residence is the state in which they are physically residing.

2053.04 - For all other institutionalized individuals, the state of residence is the state in which the individual is living with the intention to remain there permanently or for an indefinite period.

NOTE: In addition Kansas has entered into interstate residence agreements with the following states: California, Florida, Kentucky, New Mexico, Ohio, Pennsylvania, South Dakota, Tennessee, Texas, and Wisconsin. The agreement states that individuals residing in a Medicaid approved institution for long term care in one of the above-named states who would be Kansas residents under (2) or (3) shall be deemed residents of that state for purposes of medical assistance unless the person was placed there by Kansas state or local government personnel. The reciprocal situation is also covered in the

agreement. Refer to KEESM 8112 for definition of a Medicaid approved institution.

02060 Cooperation with CSE -

2061 Cooperation With and Referral to Child Support Enforcement - As a condition of eligibility in the MA/CM Program, the caretaker who is applying for or receiving assistance shall cooperate with the agency in establishing the paternity of a child born out-of-wedlock with respect to whom assistance is requested or received and in obtaining medical support payments for such caretaker and for a child with respect to whom said assistance is claimed.

See ^2066^ for effect on eligibility for failure to cooperate. For purposes of establishing paternity, the legal parent is presumed to be the biological parent. For MA CM purposes, for situations in which the alleged father is in the home, but paternity must be established, see ^2069^. For Medicaid there is no requirement that paternity be formally established as specified in ^2069^. If the parents were not married, verification methods such as obtaining a birth certificate listing both parents or a statement from the father voluntary acknowledging paternity are acceptable. The prudent person concept shall be used.

2062 Cooperation - CSE is responsible for determining whether the caretaker has cooperated in establishing paternity and/or in obtaining support. EES and/or the Case Manager are responsible for determining whether the caretaker has good cause for refusing to cooperate. Cooperation is defined as:

2062.01 - Appearing at the local CSE office or the Court Trustee Office as necessary to provide information or documentation relative to establishing paternity of a child born out-of-wedlock, identifying and locating the absent parent, and obtaining support payments;

2062.02 - Appearing as a witness at court or other proceedings necessary to achieve the CSE objectives;

2062.03 - Forwarding to the CSE unit any support payments received from the absent parent which are covered by the support assignment;

2062.04 - Providing information, or attesting to the lack of information,

under the penalty of perjury; and

2062.05 - Establishing an agreement with CSE for repayment of assigned support which was received directly and retained by the caretaker relative and maintaining payments under the terms of such a repayment agreement.

NOTE: Case Managers are to notify CSE of those cases in which there is suspected noncooperation such as when the client retains assigned support.

2063 Good Cause for Failure to Cooperate - In rare instances the caretaker may be deemed to have good cause for refusing to cooperate in establishing paternity and securing support payments. Examples of such cases would be those in which it has been determined that pursuing paternity/support is against the best interest of the child or the caretaker. Medical Workers have the ultimate responsibility for determining the validity of good cause claims; CSE and Children and Family Services staff may also be involved in making a recommendation for such determinations to Medical Case Managers.

The caretaker is primarily responsible for providing documentary evidence required to substantiate a good cause claim. When necessary, the agency shall assist the client in securing any evidence that the client cannot reasonably obtain.

Good cause for failure to cooperate must relate to one of the following criteria:

2063.01 - The child was conceived as a result of incest or rape;

2063.02 - There are legal proceedings for adoption of the child pending before a court;

2063.03 - The caretaker is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption;

2063.04 - The caretaker was a victim of domestic violence whereby compliance with program requirements would increase risk of harm for the individual or any children in the individual's case. Domestic violence includes acts on the part of perpetrators that result in:

(1) - physical acts resulting in, or threatening to result in, physical injury;

(2) - sexual abuse, sexual activity involving dependent children, or threats of or attempts at sexual abuse;

(3) - mental abuse, including threats, intimidation, acts designed to induce terror, or restraints on liberty, or;

(4) - deprivation of medical care, housing, food or other necessities of life.

2063.05 - Good cause claims must be confirmed or substantiated. Uncorroborated statements of the caretaker do not constitute documentary evidence; the mere belief that pursuing paternity or support is not in the client's or the child's best interest is not sufficient evidence. An individual's statement and one corroborating piece of evidence shall meet the burden of proof unless there is an independent reasonable basis to doubt the veracity of the statement. Evidence may include, but is not limited to:

(1) - Police or court records,

(2) - Court documents which indicate that legal proceedings for adoption of the child are pending,

(3) - Protection from abuse (PFA) orders (filed for and/or obtained),

(4) - Written statement from a public or licensed private social agency substantiating the fact that the client is involved in resolving the issue of whether to keep or relinquish the child for adoption,

(5) - Documentation from a shelter worker, attorney, clergy, medical or other professional from whom the client has sought assistance,

(6) - Other corroborating evidence such as a statement from any other individual with knowledge of the circumstances which provide the basis for the claim, or physical evidence of domestic violence or any other evidence which supports the statement.

Exception: Regardless of the policy in this section regarding

uncorroborated statements by caretakers, in extremely rare situations such as when an individual is in hiding and is afraid that there could be information disclosed that could reveal her whereabouts and where the Case Manager does not doubt the veracity of the individual's statement, a written statement from the victim signed under penalty of perjury shall meet the burden of proof.

In most instances a good cause determination should be made within 60 days following the receipt of such claim. Exceptions to this would include such situations as when the evidence is extremely difficult to obtain.

The case manager is responsible for notifying CSE of pending good cause claims and subsequent determinations. On new cases this can often be accomplished at the time initial eligibility is determined. The good cause provisions do not negate the timely referral of absent parent cases to CSE. Once a claim of good cause has been substantiated, it shall be reviewed as often as necessary and at each periodic review.

The case manager shall not deny, delay, or discontinue assistance pending a good cause determination as long as the caretaker has complied with the requirement of providing evidence or other necessary information. If assistance is granted pending a determination of good cause and it is subsequently determined that the claim is invalid, the assistance granted shall not be considered an overpayment.

NOTE: Do not confuse cases that involve good cause with routine cases of noncooperation. A client's claim of good cause does not negate the requirement for the assignment of support rights.

2064 Referral to Child Support Enforcement - Referral to Child Support Enforcement - The Case Manager is responsible for referring all absent parent cases (including a deceased parent) to CSE. MA CM Family Medical cases with a non-pregnant participating adult who is requesting or receiving coverage shall also be referred. Families requesting medical coverage only for children may elect to participate with CSE but are not required to be referred. See ^2072^ for voluntary referrals.

It is the function of the case manager to determine continued absence and the function of the CSE staff to obtain support in behalf of the spouse and/or child(ren).

The following information provides guidelines for ongoing cases related to absence from the home:

One or two indications that the absent parent has given the address of the assistance household as his or her address should be treated only as clues for further agency action. The responsibility rests with the agency and cannot be transferred to the parent in the home. Minimally, there must be an interview with (or documented attempts to interview) the absent parent.

If another address (not just for receipt of mail), is established for the absent parent, then he or she cannot be considered as being in the home without substantial data to establish that he or she is actually living there. Lacking such information, if both deny the absent parent's presence in the home, there must be several evidences substantiating presence in the home on an ongoing and current basis before agency action is taken. Such indicators might include address of the assistance household used at the post office, rent receipts in the name of the absent parent for the address of the household, utility bills for two or more months in the name of the absent parent and paid by him or her, other address of the household used at the time of the absent parent's employment over a period of time. Such documentation must be made before taking further action. Since many low income mothers are unable to obtain credit on their own, the documentation of the mother using a charge account in the name of the absent father is not sound data.

For Family Medical, the referral is an automatic process in KAECSES following completion of appropriate screens including SPRD (Specified Relative/Deprivation/Child Support) and CHSE (Child Support Enforcement Referral) and authorization of the program. Subsequent changes (such as the addition or removal of persons from the assistance plan, suspensions, closures, and inter-county transfers) are also communicated automatically in KAECSES. Referrals and subsequent changes are not made when there is no absent parent or when parental rights have been severed. See the KAECSES User Manual for further information on system processing.

2065 **Assignment of Support and Effective Date of Assignment** - For Medicaid purposes, an application for or the receipt of benefits shall constitute an assignment of support rights and limited power of attorney to the Secretary of SRS. The assignment includes any accrued, present or future rights to support from any other person that the client may have in their own behalf or in behalf of any family member for whom the client receives assistance. If the client is excluded from the MA/CM assistance plan, the assignment does not pertain to alimony. The assignment of support rights and limited power of attorney will

automatically become effective without the requirement that any document be signed by the client. Clients are to be advised of the statutory assignment provisions and to submit to the CSE unit all support received by the client on or after the date of approval. Support is subject to assignment when it is actually received by the client.

The effective date of the automatic assignment shall be the date of approval except when the first eligible month is a future month in which case the assignment shall be effective the first day of the first eligible month.

The assignment applies to court ordered and voluntary cash support as well as medical support for MA CM purposes but only to medical support for Medicaid purposes. Also see ^5300^. In most instances, an assignment ceases to be in effect the last day of the calendar month for which assistance is received. For instances in which cash assistance stops, but medical continues (e.g., TransMed or poverty level Medicaid), the assignment of medical support continues to be in effect as long as medical assistance is provided.

The client must be advised as to the effective date of the assignment.

For MA/CM purposes, spouse support can include voluntary support, military allotments, support orders and alimony (not including property settlements). Designated spouse support in MA CM is treated as a refund to SRS. Spouse support undifferentiated from and in combination with child support shall be treated as child support. Support paid in kind is exempt under the provisions of ^5500^ and is not considered in assistance budgeting. Following the effective date of assignment, assigned support is not counted as income except the support which is retained during a period when a sanction for failure to cooperate is in effect shall be counted as income. Back support subject to SRS claim is exempt from consideration. See ^5300^ & ^5500^ for other provisions regarding treatment of child support.

2066 **Failure to Cooperate** - There is no penalty in Medicaid if the caretaker refuses to cooperate unless such person is otherwise eligible for MA CM. In these instances, only the caretaker shall be ineligible for assistance unless he or she is found to have good cause for refusing to cooperate. However, medical coverage under all other categories shall be considered for such a caretaker at the time the penalty is applied (see Policy Memo 99-10-10). No penalty is applied to pregnant women and children continuously eligible under ^2301^ and ^2311^.

Because penalties only affect coverage under the Family Medical program, persons currently serving a penalty who later meet categorical

requirements under another program shall have eligibility determined under the new medical program without regard to the penalty. Because penalties can result in a temporary hardship to the family without other alternatives of support, penalties must be applied with much care and consideration. To ensure that penalties are applied uniformly and appropriately, the following guidelines must be applied in all instances of noncooperation:

2066.01 - There is documented evidence that the person was made aware of the cooperation requirement.

2066.02 - There is documented evidence that the person was informed of the consequences for failing to cooperate. Documentation that the IM-3102, Important Information About Cooperation, was discussed and distributed to the client fulfills this guideline.

2066.03 - At the point noncooperation is first reported or discovered, EES and/or the Case Manager must check with Children and Family Services (CFS) to determine if there is any CFS activity with the family that might support good cause for failing to meet requirements.

2066.04 - If good cause is not established, the EES or Case Manager supervisor must review the case circumstances before final action to apply the penalty can be taken.

2067 Medical Noncooperation - For Family Medical, only the non-pregnant adult caretaker is ineligible until the failure or refusal ceases.

For medical, the above periods of ineligibility also apply to recipients. However, only the non-pregnant adult caretaker is ineligible if he/she is covered under Medicaid. There is no penalty for other members of the assistance plan.

A denial or penalty for failure to meet CSE requirements can be imposed only when the caretaker is referred to CSE and CSE determines the person has not cooperated. This may occur after the case is approved, or if local arrangements are made between Health Care Policy/Medical Policy and CSE, may occur as part of the application process resulting in a denial at initial determination. If a previous finding of non-cooperation exists that was incurred as a result of a required referral which required cooperation, the caretaker must be given the opportunity to cooperate prior to denying assistance. Previous non-cooperation by a voluntary household does not impact future

assistance. In the following application situations, the person must be referred to CSE and cooperation established in order for there to be eligibility: a) when a prior determination of noncooperation with CSE is yet unresolved; or b) during the process of paternity establishment of the alleged father in the home per ^2069^.

If cooperation is established, eligibility shall be reinstated effective the day the individual initially agrees to cooperate and if necessary reapplies for assistance, or reinstated effective the first day of the month in which cooperation is established if there is no break in assistance.

2068 Reporting of Support to case manager - The amount of current support received on each MA CM case is reported to the case manager automatically in KAECSES. The case manager shall determine whether or not there is continuing eligibility if the amount of reported support is treated as nonexempt income. (See ^5300^, ^5500^ and ^6100^.)

2069 Paternity of Alleged Father in the Home (Not Applicable to Medicaid) - For situations in which the father is in the home with the child, paternity must be established when MA EM is requested. This provision shall apply to any instance in which both parents (or the father if the mother is not present) in the home claim(s) he is the father, unless either the father or child is excluded from the assistance plan for reasons other than a sanction or other special provision as referenced in KEESM 4120(4). This provision is not applicable while the child is unborn. See KEESM 4100 and subsections for assistance planning provisions involving paternity. Paternity for this purpose must be established in one of the following ways:

2069.01 - The parents were married at the time of the child's birth. For purposes of this provision, a common law marriage shall not establish paternity;

2069.02 - Paternity has been established through appropriate court action; or

2069.03 - The father voluntarily acknowledges paternity and the mother and father have signed the required papers for a voluntary order.

2069.04 - The father is listed on the child's official birth certificate, issued by Vital Statistics, as the child's father. This provision only applies to children born on or after July 1, 1994. This provision does not apply if either of the following conditions

exist:

(1) The mother was legally married to someone else at the time of the child's birth; or

(2) The mother was divorced within 300 days of the child's birth.

In the two above situations, HCP is to make a regular referral to CSE for paternity establishment. These paternities must be resolved by a court.

2070 **Expedited Paternity Establishment** - If paternity is not established through items (1) or (2) above, an immediate referral is to be made to CSE for paternity establishment. This may occur at the time of initial application or when the father begins living in the home at a later time. Since CSE staff are not stationed in all SRS area offices, each area must establish local procedures and timeliness for assuring that cases needing paternity establishment are treated as a high priority. If the mother and father state that he is the biological father of the child, the Case Manager shall provide notice to the mother and father that they must contact CSE within a prescribed period of time and cooperate in establishing paternity. A copy of the notice and any supporting documentation as established by the area are to be sent to the appropriate CSE Unit. Following this, one of the following actions will occur:

2070.01 - If either the mother or father fails to contact or otherwise cooperate with CSE or chooses not to sign the required paternity related forms, CSE shall promptly notify the Case Manager.

Failure of the mother or father to cooperate in establishing paternity by not contacting CSE or refusing to sign required documents for reasons other than claiming his paternity to the child is questionable shall result in ineligibility for the mandatory filing unit of the child per provisions in ^2066^.

If the father cooperates, but chooses not to sign required documents because paternity is questioned, he shall be treated as a nonrelative to the child(ren) in question. If she refuses to sign required documents because she states the paternity is questionable, she will be eligible as long as she otherwise cooperates in the establishment of paternity. In these situations, the Case Manager will process the application or ongoing case

based on the absence of the father. On the system generated referral to CSE, the Case Manager is to make the notation on the message line of CHSE for the child(ren) whose paternity is in question: "Paternity Referral - Alleged father in the home." This will alert CSE that urgent action is needed for an involuntary paternity action.

2070.02 - If the mother and alleged father contact CSE and, following disclosure of basic information including rights and responsibilities, sign the required paper(s), MA EM will notify the Case Manager that paternity has been acknowledged.

Generally, the process can be accomplished within ten working days. Upon receipt of this notification, the Case Manager is to proceed with the eligibility determination. If the family is eligible for MA CM, the Case Manager is to notify CSE which will enable CSE to take appropriate follow-up action on the CSE case.

2071 Special Case Situations -

2071.01 Legal vs. Biological (Alleged) Father - In these situations the mother is currently or was married to a different person at the time she was pregnant or during the child's birth. This establishes a legal father contrary to claims that the real (biological) father is in the home. When these circumstances are identified, both the mother and alleged father may volunteer for referral to CSE pending the eligibility determination. In the contact CSE will be able to do a more in-depth analysis of the circumstances at the time of the child's birth and advise the clients of legal aspects of the situation. If CSE responds that a voluntary order is obtained, the Case Manager will process the case considering paternity established with the father in the home. However, in most instances CSE's response may be that a legal father exists and a voluntary order is not possible. If the persons do not volunteer or do not follow through with this referral to CSE pending eligibility, or if CSE responds that a voluntary order is not possible, the alleged father is to be treated as a nonrelative to the child in question and the case is to be processed in that manner. In such instances, the CHSE screen should list the legal father as the absent parent and a narrative message "Paternity Referral-Legal vs. Alleged Father" included. Since this initial process is voluntary, the mother and children are not subject to loss of assistance or penalty prior to approval. However, a penalty is applicable if she fails to

cooperate with any CSE requirements following case approval.

2071.02 **Minor Parent** - If one parent is an adult and the other emancipated or if both parents are emancipated, the case is to be treated as though both are adults and handled as described at the beginning of this section (i.e., screened for paternity establishment, referred to CSE pending eligibility if necessary and penalties applied to the mandatory filing unit for noncooperation). See ^2010^ for emancipation requirements. Note that this provision does not apply if either parent is able to act in own behalf only through provisions in ^2010^.

If either parent is a minor and not emancipated, CSE cannot expeditiously process a voluntary order. This is because appointment of a guardian ad litem is required and generally takes considerable time. For these situations (or if paternity is otherwise established by marriage or court order), the case may be approved treating him as the father without a referral to CSE pending eligibility. A referral must be made to CSE at the time of case approval, however, if paternity is not otherwise established. In order to make an electronic referral in these situations, the child should procedurally be coded with a "CA" deprivation cause code on SPRD even though there is no absent parent. The CHSE screen should be completed with information on the minor father and a narrative message "Minor Parent Paternity Referral" included.

2071.03 **Single Parent Father** - This situation addresses circumstances in which the father is in the home while the mother is absent, and he is unable to document paternity to a child(ren) through marriage or a court order.

If the mother is available (e.g., lives in the community) and agrees to cooperate in the process, or if she is deceased and substantiation of death is readily available, a referral to CSE for paternity establishment pending eligibility is required and handled per general instructions earlier in this section.

If he fails to cooperate, the mandatory filing unit is ineligible. If he cooperates, but does not sign a voluntary order because he questions paternity, he is treated as a nonrelative to the child and can receive assistance only if he otherwise qualifies as a caretaker.

If the mother is not available or if documentation of her death is

not readily available, the case is to be processed treating him as the father provided other documentation and/or prudent person judgment would merit such. Upon case approval, the CHSE screen must be completed listing the mother as the absent parent and a narrative message "Single Parent Father" included. The father continues to be required to cooperate or the mandatory filing unit is subject to loss of eligibility per ^2066^ above.

After the case has been processed either including or excluding persons as appropriate, the qualifying parent(s) continues to be responsible to cooperate in establishing or finalizing paternity as necessary. Failure to do so shall result in ineligibility for assistance per provisions in ^2066^ above.

2072 Voluntary Referral (Medical, except Family Medical) - All households which include a child whose parent(s) is absent may voluntarily request to be referred to CSE. CSE will help with establishing paternity if not already established, and obtaining support. For medical cases not subject to the mandatory referral per ^2064^, clients requesting CSE services shall be given the name and phone number of the appropriate contact person in the local CSE office. No automated process is in place for referring voluntary CSE participants.

For MA/CM households, refer to KEESM 2550. Failure to cooperate with CSE does not impact medical coverage except as noted in ^2066^ for caretakers requesting or receiving medical.

A previous finding of noncooperation by a voluntary household shall not impact future assistance under any program, including delayed processing per ^2066.01^.

02100 Child in Family - There must be at least one child in the home or qualifying under temporary absence provisions of ^2110^. In order for any family member to qualify, a child must be included in the assistance plan for MA/CM benefits unless the child is: (a) unborn; or (b) excluded as an SSI recipient. When the only child is an unborn, the woman must be medically verified to be pregnant. See KEESM 4100 for assistance planning provisions for MA CM.

NOTE: Children in state custody placed with a caretaker are not entitled to receive both MA CM medical coverage and foster care medical coverage in the same month. Also, families working with Child Welfare Community Based Service (CWCBS) Providers for the receipt of foster care payments for children who have been placed with them are not entitled to receive MA CM for those children. (See ^5500^) However, a dependent child of a foster care recipient

shall have his or her needs met through MA CM if the dependent child and recipient are living together in a foster family home, the dependent child is not in SRS custody, and other MA CM requirements are met. Please refer to EES Policy Memo No. 01-02-02.

A child must be an unborn child, under 18 years of age, or age 18 and working toward attainment of a high school diploma or its equivalent, including students attending a home school that is registered with the Kansas Department of Education. The person may be considered a child the entire month he or she turns 18, or if pursuing a high school diploma or its equivalent the entire month he or she turns age 19. A person acting in their own behalf per ^2010^ is not considered a child for MA CM purposes.

The statement of the applicant in regard to the month and day of the birth of the child will be accepted by the agency unless there is reason to question its authenticity or unless evidence establishes the month and day of birth as being different from that given by the applicant. If the agency establishes a month and day, that will be considered as the actual date of birth for the child. Age may be established by means of official papers, other written documents, birth registrations or, in exceptional cases, by the use of affidavits if verification is needed.

If the applicant is not able to give the month and day of birth for a child and if the agency is unable to establish any month and day, July 1 is to be used arbitrarily as the child's birth date.

02110 Living With a Caretaker - A child must be living in a home with a caretaker. A person must have one of the following relationships to the child in order to be a caretaker under this provision:

2110.01 - Any blood relative (or one of half-blood) who is within the fifth degree of kinship to the dependent child. An appropriate relative is therefore a parent, (biological or adoptive) grandparent, sibling, great-grandparent, uncle or aunt, nephew or niece, great-great grandparent, great uncle or aunt, first cousin, great-great-great grandparent, great-great uncle or aunt, or a first cousin once removed.

An example of a great uncle would be the brother of the grandparent of the dependent child. An example of the great-great uncle would be the brother of the great grandparent of the dependent child. An example of a first cousin once removed who would qualify as a caretaker would be an adult child of a first cousin of the dependent child. Another example of first cousins once removed would be in the relationship between a

dependent child and the first cousin of that child's parent. Second cousins are not within the allowable degree of relationship. An example of second cousins would be two persons whose parents are first cousins. See the KEESM Appendix Section T-6 for illustrations of allowable relationships.

2110.02 - A step-father, step-mother, step-brother, step-sister, step-grandparent, step-aunt, or step-uncle.

2110.03 - Legally adoptive parents and other relatives of adoptive parents as designated in groups (1) and (2).

2110.04 - A person who is court-appointed to be:

(1) - a guardian;

(2) - a conservator; or

(3) - the legal custodian.

2110.05 - The spouses or former spouses (after marriage is terminated by death or divorce) of any persons named in the above groups.

When a person in the home with a child is considered the father based on statements from the client(s) or other documentation as appropriate, he shall be treated as the father for purposes of the provision. However, if in accordance with the provisions in ^2069^, he is referred to CSE for a voluntary paternity acknowledgment and he cooperates but chooses not to sign necessary documents because he questions that paternity, he shall no longer be treated as the father and would not be an allowable caretaker based on that relationship. He may qualify as a caretaker based on another relationship to the child, however (e.g., stepparent based on marriage to the mother after the birth of the child).

As long as the caretaker has day to day responsibilities for the care and control of the child, eligibility continues even though the child is under the jurisdiction of a court for probation or protective supervision, or legal custody is held by an agency that does not have physical possession of the child.

Note: There are situations in which the rule that a child must be living with a caretaker will conflict with the mandatory filing

unit rule. For example, John applies for TAF for himself and his two sons. Also living in his home is Scott, his children's half-brother, who has the same mother but a different father. The boys' mother and John were never married, even by common law; therefore, there is no caretaker relationship between John and Scott. The three boys are a mandatory filing unit, however, due to their blood relationship. The father is also part of this mandatory filing unit because he is legally responsible for his two sons. In this and similar situations, the mandatory filing unit rules will take precedence over the caretaker relative rules. The assistance plan must include John, and all three boys.

02120 **Joint Custody** - Joint Custody Situations - In situations of joint custody where a child resides with each parent within a calendar month, the parent who has the primary responsibility for exercising parental control, and has the child over 50% of the time, shall be the qualifying caretaker and may apply for and receive MA CM for that child if otherwise eligible. Eligibility for the child or children in joint custody cannot be split between the separate parents; therefore, both parents cannot receive benefits for the same child for the same month. If neither parent can be shown to be the parent with whom the child resides over 50% of the time and no other factor shows that one parent has the primary responsibility for the child, then the parents must designate which household will include the child.

02130 **Minor Parent Not Living with Caretaker** - A minor parent (including a minor expectant mother or father) who is not able to act in own behalf per ^2010^ and not living with a caretaker as defined in this section may qualify for assistance provided an adult in the family group is applying for or receiving assistance on the minor parent's behalf. Examples: A minor father living with his child and the child's grandmother (not the minor father's parent) can be eligible even though the grandmother does not qualify as a caretaker to the minor father. A pregnant minor not able to act in own behalf living with her unborn's adult father can be eligible even though the father does not qualify as a caretaker to the minor mother.

NOTE: Anytime a minor's health or safety is judged to be at risk, a referral to Children and Family Services would be appropriate.

02140 **Temporary Absence of A Child or Caretaker** - A child or caretaker who remains a part of the household, but is, or is expected to be, out of the home for 180 consecutive days or less, shall, if otherwise eligible, qualify to receive assistance. In addition, a caretaker who is out of the home for employment or to fulfill a work requirement shall also qualify as a part of the household regardless of the length of time away. A child who is out of the home for a

temporary visit with the non custodial parent and who is expected to return within 180 days shall remain on the custodial parent's medical case and CSE (if MA CM) shall be notified of the absence. A child out of the home attending school or in Job Corps remains a part of the household as long as he/she intends to return to the household, regardless of the expected length of absence. The determining factor in the case of a temporarily absent child shall be the caretaker's continued responsibility for the care and control of the absent child. The determining factor in the case of a temporarily absent caretaker shall be the caretaker's continued responsibility for the care and control of the children remaining in the home.

02200 General Program Information for Title 19 - Medicaid benefits are provided to help cover the cost of health care for an individual. Medicaid is a federally regulated and state administered program which is jointly funded by the federal and state government. It covers the majority of the state's medical recipients including children and pregnant women.

The Medicaid program provides payments for comprehensive medical care and services furnished either through managed care entities or by enrolled providers within the scope of their practice as defined by state law and within the scope of services covered by SRS. Specific services for which payment can be made and the proper payment rate (including capitation rates for managed care) are established by the Health Care Policy Division and are reviewed and adjusted periodically. Information on covered services can normally be obtained by the provider. Each provider is given a policy and procedure manual providing instructions related to coverage and processing claims; additional information can be obtained by the provider from the fiscal agent or Health Care Policy. The local SRS office has responsibility for establishing eligibility/ineligibility of applicants/recipients based on the policies established within the limitations set forth by the Code of Federal Regulations and the Kansas Administrative Regulations. Licensed or certified medical practitioners determine the necessity of specified medical services, subject to review by the Health Care Policy Division or other SRS personnel. Payments (either capitated payments or direct service payments) are made directly to the provider (vendor) of medical services rendered to individuals certified as eligible. SRS contracts with a fiscal agent to process medical claims. The current fiscal agent is Electronic Data Systems (EDS).

Medical programs are funded by the Kansas State Legislature through SRS. Title XIX of the Social Security Act authorizes federal financial participation (FFP) in medical payments for Medicaid covered individuals as well as specifies basic eligibility and service requirements. In addition, the income and resource methodologies of the TAF program affect Medicaid eligibility in the children and pregnant women categories while those methodologies of the SSI program affect the Medicaid eligibility in the aged and disabled categories. Financial eligibility rules are the same as those used in Medicaid program for

nondisabled children. The MediKan program is directly tied to the GA cash program and authorized through state legislation as well as the Kansas Administrative Regulations.

02210 Medicaid - The Medicaid program is divided into two segments, the "categorically needy" and the "medically needy."

2211 Categorically Needy - Those persons who are eligible for a cash benefit under the SSI program or who meet Family Medical guidelines comprise a good portion of the categorically needy. Children and pregnant women who, although ineligible for cash assistance, have incomes that fall below certain poverty level guidelines also are classified within this group.

The categorically needy receive medical assistance either because their income falls within poverty or Family Medical income guidelines or as a result of SSI eligibility. Within the categorically needy segment are also those persons who are "deemed" to be receiving an SSI cash benefit or Family Medical although ineligible for one due to certain financial or non-financial factors. For Family Medical, this would include persons who become ineligible due to increased earnings or hours of employment or because of loss of the earned income disregards (6 months of TransMed benefits), persons ineligible for cash assistance because of requirements that do not apply to medical, and persons who do not receive cash benefits because of the recovery of an entire grant for overpayment purposes. For SSI, this would include persons qualifying based on the Pickle Amendment provisions and persons who qualify for 1619(b) status under the SSI program benefits because they are working but who retain disability.

Coverage of the categorically needy is largely mandated by federal law with some limited options.

2211.01 - The mandatory groups include:

(1) - Persons meeting Family Medical criteria (including TAF recipients) as well as those deemed to meet the criteria.

(2) - SSI recipients, including those deemed to be receiving SSI.

(3) - Pregnant women and children under the age of 1 whose countable income does not exceed 150% of the federal poverty level.

(4) - Children ages 1 through 5 whose countable income does not exceed 133% of the federal poverty level.

(5) - Children ages 6 through 18 whose countable income does not exceed 100% of the federal poverty level.

2212 **Medically Needy** - The medically needy segment is comprised of those persons, who while meeting the non-financial criteria of one of the categorically needy programs such as age or disability, do not qualify because of excess income or resources or, in the case of pregnant women and children, have income which exceeds the poverty level guidelines of either Medicaid or HealthWave. Most persons in the medically needy group are obligated for a share of their medical costs through the "spenddown" process. Coverage of this group is optional under federal law. If a state chooses this option, it must cover pregnant women (including coverage of the 60 day postpartum period) and children. Kansas provides coverage for the following groups:

(1) - Pregnant women

(2) - Children up to age 18 or age 18 and working toward the attainment of a high school diploma or its equivalent

(3) - Persons 65 years of age and older

(4) - Persons who are disabled or blind under SSA standards. Medically needy coverage can also be provided to caretaker relatives of dependent children but Kansas does not currently provide for this.

02220 **Medical Coverage for Families** -

2221 **Medical Coverage for Families and Medical Assistance Related to the Cash Program** - Medical coverage is available to families with children under the Family Medical program and to certain recipients of cash assistance if the requirements specified below are met. This includes those who lose eligibility under the Family Medical program and qualify under the extended medical provisions (TransMed and 4 month extended).

2222 **Family Medical Coverage (associated with TAF and MA-CM)** - Persons meeting the following criteria, whether receiving TAF benefits or not, are eligible for medical coverage under the Family Medical program

2222.01 **General Eligibility Requirements** - General eligibility requirements of act in own behalf (^2010^), cooperation (^2021^), not receiving SSI (KEESM 2630), SSN (^2031^), citizenship and alienage (^2041^) and residency (^2051^) must be met. In addition, the age and caretaker requirements of ^2100^ and ^2110^ must be met. The assistance planning provisions of KEESM 4100 are also applicable including the mandatory filing unit rules.

The Fugitive felon (KEESM 2182) and drug related conviction (KEESM 2183) requirements are not applicable to the determination of MA CM Family Medical coverage.

2222.02 **Financial Eligibility** - All people receiving a TAF cash benefit shall also be eligible for medical benefits provided under the MA CM Family Medical program. For others, the financial determination must take into account the provisions of ^5100^, and subsections.

Income to be counted shall either be converted or averaged in accordance with ^6112^ and subsections. All other TAF treatment of income rules are applicable in the determination, including the 40% disregard and associated one in four preceding months initial criteria rules specified in ^6222^. If the countable income obtained is less than the appropriate cash need standard for the family size (shared or non-shared) the family is eligible provided all other eligibility criteria are met. There is no resource test for Family Medical, unless a nonexempt trust exists (see ^4010^). Persons ineligible for TAF because of excess resources may be eligible for MA CM.

All persons meeting these requirements may receive coverage under this program. This includes TAF recipients who are eligible for a payment of less than $10.00 (see KEESM 1512.5(1)). It also includes persons who would be otherwise eligible for TAF cash assistance except for the prohibition regarding duplicate payments from another state. Such persons can qualify for a medical card in Kansas if they are otherwise eligible for TAF in Kansas including having countable income below Kansas standards. Any grant amount received from the other state shall be exempt as income in this determination.

The MA-CM program designation shall be used to provide medical coverage for both TAF and non-TAF recipients. For non-TAF recipients eligibility is computed using the MA-CM Electronic Worksheet (KEESM Appendix Item W-6). This

form is also located on the SRS Intranet. Because all TAF recipients shall continue to receive Medicaid under the Family Medical program, a separate determination is not required.

NOTE: A separate determination of medical eligibility IS required for all persons denied TAF benefits, including those denied for failure to complete an interview.

A determination shall initially be completed under the Family Medical program, but shall also consider possible medical eligibility under all other categories. In addition, a determination of expedited medical eligibility is initially required for all pregnant women applicants.

2222.03 **Coverage Limitation** - Coverage shall not be provided under the Family Medical program to the following:

(1) - Persons convicted of medical fraud per ^8420^.

(2) - Persons who have a special spenddown per ^8362.03^.

(3) - Non-pregnant adult caretakers who fail to cooperate with child support enforcement per ^2061^ and subsections. A period of ineligibility shall be imposed on such persons as per ^2067^. Medical coverage is not available to penalized individuals under the Family Medical program until the failure or refusal ceases. However, the possibility of medical eligibility under other determined medical programs shall be considered at the point the penalty is applied, based in ex parte guidelines and before medical coverage is terminated.

2222.04 **Continuation of Coverage** - Family medical coverage shall continue through the end of the established review period for those persons whose TAF cash benefits terminate if the only reason for termination is due to a failure to comply with the reporting requirements of KEESM 9100, the work-related requirements of KEESM 3500, or the Quality Assurance requirements of KEESM 2123 or excess resources per KEESM 5130. The person must also continue to meet financial and nonfinancial criteria. An ex parte redetermination of ongoing eligibility for medical coverage is required for all individuals upon the termination of cash eligibility (see Policy Memo 99-10-10). Medical coverage will continue to be provided during this determination.

Family Medical coverage shall be determined independent of any cash fraud disqualification penalty. Persons otherwise eligible shall continue to receive Family Medical coverage when a cash disqualification penalty is applied.

The Family Medical household is required to report applicable changes within ten days. However, if a Family Medical recipient is also receiving TAF cash assistance and is required to monthly report, changes reported on the monthly report form shall be considered timely even if reported after ten days.

Once financial eligibility is established in the Family Medical program, the continuous eligibility provisions of ^2301^, ^2311^ and ^2320^ are applicable to pregnant women, children and newborns. Eligibility will continue to be provided to those individuals under the Family Medical program until the end of the individual's continuous eligibility period as established in these sections even if the household no longer meets financial criteria.

All Family Medical cases shall be reviewed once every twelve months (see ^7442^).

02230 Transitional Medical Coverage -

2231 Transitional Medical Coverage (TransMed) - Persons receiving Family Medical coverage are eligible for medical coverage for a period not to exceed 12 months when the provisions in this section are met.

FFP is available for the medical coverage of all persons who qualify for TransMed.

2231.01 General Eligibility Requirements - General eligibility requirements of act in own behalf (^2010^), cooperation (^2021^), not receiving SSI (KEESM 2630), SSN requirements (^2031^), citizenship and alienage (^2041^) and residency (^2051^) must be met. If not, the individual is ineligible for TransMed. CSE cooperation is not required for TransMed.

2231.02 Other Eligibility Requirements for the Initial 6 Months - Eligibility for TransMed shall be established for the first six-month period for each participating member of the Family Medical assistance plan who has:

(1) - Lost eligibility for Family Medical due solely to a

recipient caretaker's increase earnings resulting from increased hours of employment or monetary increase in the amount paid for hours of work. The increased earnings must cause the ineligibility. If there is also an increase in other income since the previous month's budgetary determination, then ineligibility must be shown to result solely from the increased earnings without factoring in the increase in that other income.

NOTE: A person who enters the home with earnings causing the loss of Family Medical coverage will not qualify the family for TransMed since the person with the earnings was not a recipient.

If loss of coverage can be directly attributable to one of the above factors, TransMed eligibility must be established without regard to other reasons the case may have become ineligible for Family Medical coverage.

(2) - Been included in a Family Medical plan in which one or more persons correctly received Family Medical in at least 3 of the 6 months immediately preceding the first month of TransMed.

2231.03 **Establishing the initial 6- month Coverage Period** - The initial 6-month period in which a family is eligible for TransMed is determined as follows:

(1) - For families who are also receiving TAF cash, the TransMed period begins the first month in which there is no eligibility for TAF and Family Medical benefits because of excess earnings. For example, a family reports an increase in earnings on 9/10/2003. The first month of ineligibility for TAF cash and Family Medical, is 10/2003. TransMed coverage begins 10/1/2003.

(2) - For families who are not receiving TAF cash assistance the TransMed period begins the first month after the increase in earnings is timely reported, providing for timely notice requirements. For example, the same individual in item (1) above reports on 9/25 that she has a new job with increased earnings that put her family over the income limit for MA-CM. Because of timely notice requirements, coverage under the MA-CM program terminates effective 10/31/2003. The first month of TransMed coverage is 11/1/2003.

TransMed eligibility for the family must be initially established

during the first four months after loss of MA-CM eligibility. For instances in which it is subsequently determined that incorrect MA-CM coverage was in place, TransMed may be established even though it has been more than four months since there was MA-CM eligibility.

2231.04 - Eligibility Requirements for the second 6 months Individuals who continue to meet the General Eligibility Requirements of ^2231.01^ shall be granted a second 6 months of TransMed if they meet the following requirements:

(1) The family must report their gross income for the first three months of the first 6-month period by no later than the last day of the 5th month of coverage in accordance with section ^7442.03^.

(2) Once the family has reported their income, the total countable income for the family must not exceed 185% FPL. (See KEESM appendix F-1 indicates 185% of FPL.).

2231.05 **Establishing the Second 6-month Coverage Period** - The second 6-month period will start with the first month after the initial 6 - month coverage period ended (the 7th month of TransMed coverage). The end of the second 6-month period will be the 12th month of TransMed eligibility. Eligibility for TransMed will not extend beyond the 12th month of coverage, although the family may qualify again in the future if all of the criteria are met. The 12 month TransMed period is to be determined by counting only those months in which there is no eligibility for Family Medical (MA-CM) as well as the months for which it is subsequently determined that the family received Family Medical (MA-CM) benefits for which they were not eligible. (See ^8000^.)

2231.06 **Re-establishing TransMed eligibility** - Once TransMed eligibility is established, it can be reinstated at any time during the initial six-month period. However, coverage shall not be granted for more than three months prior to the month of request. If the family is reinstated during the initial six-month period, they may be granted coverage but are still subject to the reporting of the initial 3 months income by the end of the 5th month. Failure to report the first three months income and child care expenses by the end of the 5th month will result in ineligibility for the second six months of coverage. If coverage is ended at the end of the initial six months because the family

failed to report their earnings by the end of the 5th month, eligibility for TransMed cannot be re-established, unless the agency can verify that the family's failure to report was due to agency action (e.g. the agency can verify that the income review form was sent to the old address after the family had reported their new address).

If the family returns to receipt of MA-CM during any portion of the TransMed period, TransMed eligibility ceases. If financial eligibility is lost again per ^2231.02^(1) during the initially established TransMed period, the family shall either be reinstated to that existing period, or if the family can qualify, a new TransMed period is to be set. If the family does not qualify for a new TransMed period and is reinstated to the initially established TransMed period during the initial six-months, they must meet the reporting guidelines mentioned in the previous paragraph. If the family moved from TransMed to MA-CM after having already qualified for the second six-month coverage period and they do not qualify for a new TransMed period, they may be reinstated to the remainder of the second six-month eligibility period. If the family moved from TransMed to MA-CM and then lost eligibility for MA-CM again between the initial six-month period and the second six-month period and they do not qualify for a new TransMed coverage period, the family may be reinstated to the initially established TransMed period if they provide income and child care expense information within 10 days of request and meet the income guidelines of ^6410.01^.

For example, the family first qualifies for TransMed coverage in January 2004. Their six-month income review is set for June 2004. The caretaker reports that she lost her job on May 10, 2004. TransMed coverage ends on 5/31/2004 and the family becomes eligible for MA-CM effective June 1, 2004. On June 20, 2004, the caretaker reports that she is again employed and her earnings are too high for MA-CM to continue. Due to timely and adequate notice provisions, their MA-CM eligibility ends on 7/31/2004. Because they were not on MA-CM for three out of the last six months, they do not qualify for a new TransMed period. The family did not report their earnings from the first three months of coverage because they were going to transition to the MA-CM program. Before the family can be reinstated to TransMed coverage for August 2004, the worker shall request the income and child care expenses for the first three months of TransMed coverage (January, February, and March 2004). If the caretaker provides the information and the

income is less than the standard in accordance with section ^6410.01^, the family will be granted TransMed coverage beginning August 2004 and ending December 31, 2004. If the caretaker does not provide the income and expense information within 10 days, the family cannot be reinstated to the initially established TransMed period and coverage for the caretaker would end 7/31/2004. Continuous eligibility for the children, however, was re-established with the first month of MA-CM, so they will continue to be covered through 5/31/2005.

2231.07 **Individuals Leaving or Entering the Home** - Individuals who leave the family lose eligibility for TransMed. For a child, eligibility ceases when age requirements in ^2100^ are no longer met. The following individuals may be added to an existing TransMed case if other requirements are met; however, such persons shall not be granted coverage for more than three months prior to the month of request:

(1) - A person who initially qualified for TransMed with the family in the current period;

(2) - A child (including a newborn) of a current TransMed family member who enters the home or loses SSI; or;

(3) - A legally responsible person of a current TransMed family member who enters the home or loses SSI.

02240 **Four-Month Extend Medical** -

2241 **Four-Month Extend Medical** - Persons receiving Family Medical coverage are automatically eligible for medical coverage for a period not to exceed 4 months provided that the following criteria are met. (See KEESM 2653 extended medical provisions applicable to RE and MA RM recipients.)

2241.01 - They must be included in an assistance plan in which one or more persons received Family Medical in at least 3 of the 6 months immediately preceding the month in which the person(s) became ineligible for such coverage.

2241.02 - There is ineligibility due solely or partially to the budgeting of support in accordance with ^5310.01^.

2241.03 - There must still be eligibility without the budgeting of

support.

Only members of the coverage family group who were eligible for Family Medical coverage are entitled to the 4 month extended coverage. A newborn child of a recipient mother who qualifies for 4 month extended medical in her own right shall also qualify and would qualify for continuing medical coverage under the newborn provisions of ^2320^. All other nonfinancial factors of eligibility must continue to be met. Changes of circumstances occurring within the 4 month period will be assessed in terms of continued Family Medical eligibility except for the increased support, and must be reported as stated in ^7211^.

The 4 month extended period is to be determined by counting only those months in which there is no Family Medical benefit as well as the months for which it is subsequently determined that an incorrect medical benefit was provided. (See ^8000^.)

02250 SSI - Refer to KEESM 2630

02260 Additional SSI - Refer to KEESM 2637

02270 Medicaid Poverty Level -

2271 Medicaid Poverty Level Eligibles - Children under age 19 and pregnant women (including pregnant minors) shall be eligible for medical assistance without a spenddown if countable income (per ^2280^) does not exceed the following applicable limit:

2271.01 - For pregnant women and children under the age of 1, 150% of the appropriate federal Poverty Income Guidelines;

2271.02 - For children ages 1 through 5, 133% of the appropriate federal Poverty Income Guidelines; or

2271.03 - For children ages 6 through 18, 100% of the appropriate federal Poverty Income Guidelines.

However, persons convicted of medical assistance fraud shall not be eligible in accordance with ^8420^.

The poverty level programs are intended to cover children and

pregnant women who are not financially eligible for SSI or Family Medical (MA CM, TransMed, Extended Medical), as eligibility is considered for these groups first. They are applicable to all TAF related children and pregnant women and eligibility for medical assistance shall be determined first for these individuals under the poverty level provisions. Persons ineligible under the financial criteria of these programs may meet the eligibility provisions of HealthWave 21 as well as the MA or MS programs. See ^2401^ and ^2351^ and respectively.

NOTE: Persons under the age 19 who are pregnant shall first be determined under the pregnant woman provisions. If ineligible under these provisions, eligibility shall then be determined as a child under either the Medicaid or HealthWave program.

2272 **General Eligibility Requirements** - The general eligibility requirements of acting in own behalf ^2010^ (including the caretaker requirements), cooperation ^2020^, social security number ^2030^, citizenship and alienage ^2040^, and residence contained in ^2050^ must be met.

2273 **Age/Pregnancy Determination** - The child must be under the age of 19. Coverage may be provided through the end of the month of the individual's 19th birthday unless she is a pregnant woman. See ^2300^ for pregnant woman standards.

02280 **MCD Financial Eligibility** - Financial Methodologies - Financial eligibility shall be determined based solely on income. Resources shall not be considered.

For children, the needs and income of the child and his or her natural or adoptive parents, if living together, are to be considered. See the assistance planning rules contained in ^3112^. Persons age 18 and persons under age 18 who are capable of acting in their own behalf per the guidelines of ^2010^ shall be determined eligible in a separate plan. A separate case shall be established in these instances. However, for an ongoing recipient child who turns 18, action to set up a separate plan for the child is not required until the time of the next scheduled review.

For pregnant women, the needs and income of the woman, the unborn child, and the father of the unborn child, if in the home, are to be considered. In addition, for pregnant minors, the needs and income of her parents if in the home are also to be considered. No other income is to be considered.

A poverty level eligible child shall also be included in the determination of eligibility for other family members who may qualify for another medical

program (i.e., HealthWave). In a mixed family group consisting of a pregnant woman and children, separate eligibility determinations will be required. See ^3112^. However, for families in which there are both Medicaid poverty level and HealthWave eligible children, a single family determination is required.

To be eligible, the total countable income must not exceed the monthly poverty level standards referenced in the KEESM Appendix F-8.

A one month base period shall be used in accordance with ^6311^.

If countable income is in excess of the Medicaid poverty levels, the pregnant woman or child is not eligible under this provision but the child may then be eligible for HealthWave coverage. See ^2400^.

02300 Continuous Eligibility for Pregnant Women -

2301 Continuous Eligibility for Pregnant Women - Once financial eligibility is established as of the date the case is processed under any program (including FC, SI, and AS) other than HealthWave, MA (except MA CM, MA WT, & MA EM), or MS (including FC, SI, and AS), the pregnant woman shall be automatically eligible throughout the pregnancy term and the postpartum period despite any changes in income. All general eligibility factors must be met during the continuous eligibility period. This includes pursuit of third party resources per ^2021.03^, SSN requirements of ^2031^, citizenship and alienage requirements of ^2041^, and residence requirements of ^2051^. It does not include cooperation regarding countable income as changes in income do not affect continuous eligibility, loss of contact per ^7230^, or cooperation with reviews during the continuous eligibility period per ^2021.02^. This provision does not apply to women for whom expedited eligibility is established per ^1407^ but who are later determined to be ineligible because the income used to establish such eligibility was incorrect.

This provision also applies to pregnant women who had been AFDC or RE recipients and lose eligibility under those programs because income exceeds the applicable cash standard and poverty standard.

A pregnant woman who initially qualifies for Medicaid under another category shall continue to be eligible through the postpartum period even if she loses categorical eligibility under the program she was initially established under. When this occurs, eligibility shall be established under the MP program for the remainder of the continuous eligibility period. This would include pregnant persons turning 19 who are no longer eligible for child's poverty level coverage and SSI

recipients who lose disability status.

Continuous eligibility shall be provided if eligibility is established for any of the months in the prior medical period. However, if there is a break in assistance of one or more months during the continuous eligibility period, continuous eligibility shall end and the woman would have to qualify under the poverty level program again or another medical program. In addition, if continuous eligibility is not established for the month following the month regular eligibility is lost, it cannot be provided and the woman would once again have to qualify for the poverty level program or another medical program, except as noted above for TransMed.

Only one continuous eligibility period is applicable per pregnancy. Thus if one pregnancy ends during the continuous period and another begins shortly thereafter, the woman must requalify for regular poverty level eligibility for the second pregnancy before having access again to the continuous eligibility provisions.

For persons under 19 eligible under these guidelines, a 12 month continuous eligibility period applies (see ^2311^ for establishing the 12 month period). If the 12 month period ends prior to the last day of the postpartum period, continuous eligibility also continues.

2302 Postpartum Period for Pregnant Women - Eligibility for pregnant women shall continue through the 2nd calendar month following the month of birth of the child or termination of pregnancy provided the woman is or will be a Medicaid recipient for the month of birth or pregnancy termination (including prior eligibility). This provision applies not only to pregnant women who were MP recipients in that month but also to pregnant women who were eligible under another FFP medical program and lost that eligibility in the month of birth or pregnancy termination due to a change in circumstances (e.g., loss of cash eligibility). All general eligibility factors must continue to be met during the extended coverage period.

02310 Continuous Eligibility for MCD Children -

2311 Continuous Eligibility for MCD Children - Once financial eligibility is established as of the date the case is processed either under the poverty level, Family Medical (including TransMed and extended medical coverage), or MA CM program, all eligible children in a family group shall be eligible for a 12-month period (see ^3100^ for assistance planning). If a household contains both Medicaid and HealthWave eligible children, the continuous eligibility period for the Medicaid

eligible children shall be extended beyond the 12 months to provide for a family continuous eligibility period. However, if there is not current eligibility but eligibility does exist for one or more months of the prior period, continuous eligibility is established beginning with the first month of eligibility in the prior period. Children who subsequently enter a household, request assistance and are determined eligible for either HealthWave or Medicaid shall remain eligible through the family's established continuous eligibility period. Newborns eligible under the provisions of ^2320^ and pregnant women eligible under the provisions of ^2301^ shall have continuous eligibility periods established independent of the family continuous eligibility period, as the periods established for these groups take precedence for these individual family members.

When a family contains individuals eligible under any combination of poverty level children, HealthWave, newborn or pregnant women categories, individual continuous eligibility periods may differ. When this occurs, the family continuous eligibility period is established by the continuous eligibility period of the non-pregnant/non-newborn children. If the plan contains only pregnant women and/or newborns the continuous eligibility date of these individuals will determine the family continuous eligibility period, in that order.

2312 **Continuous Eligibility Period** - Continuous eligibility begins with the first month of eligibility (see ^2311^ above) in the current review period and continues regardless of any changes in income. Neither a loss of contact per ^7230^ nor the TransMed income and reporting requirements of ^2231.04^ shall affect eligibility. Such eligibility shall continue unless one of the following circumstances occurs:

2312.01 - the child turns age 19;

2312.02 - the child no longer meets residency requirements;

2312.03 - the child dies;

2312.04 - the child enters an institution or jail;

2312.05 - the child no longer lives with a caretaker who meets the criteria of ^2110^;

2312.06 - the child is found to not have been initially eligible;

2312.07 - the family fails to cooperate with any review required prior to the end of the 12-month period in accordance with ^7440^ (not including the 6 month TransMed reporting requirement of ^2231.04^). Coverage is to continue during the period in which the review is completed as long as the family is cooperating;

2312.08 - the child becomes eligible for HCBS or for SSI (including eligibility under the protected class see KEESM 2639), foster care, or adoption support assistance;

2312.09 - there is a voluntary request for case closure.

In any of the above situations, coverage shall be terminated with the month the circumstances occur or a following month allowing for timely and adequate notice. Continuous eligibility can be reestablished if there is less than a calendar month break in assistance. Otherwise, the child would have to qualify again for poverty level coverage or coverage under another medical program.

2313 **New Continuous Eligibility Period** - A new 12 month continuous eligibility period is established when one of the following occurs, even if there is a current period in effect:

2313.01 - at review per ^7440^ provided the family cooperates and remains financially eligible;

2313.02 - when a family becomes eligible for Family Medical coverage (MA CM, TransMed or extended medical benefits);

No other changes in circumstances affect the continuous eligibility period. As such, all other changes are effective at the time of the next review including other changes in income and age changes (excluding children turning age 19).

02320 **Continuous Eligibility MCD Newborns** - A child born to a woman who is eligible for and will receive medical benefits under the TAF, GA, RE, SSI, Medicaid poverty level, FC, AS, TransMed, or 4 month extended medical program for the month the child is born (including prior medical) will be automatically eligible for coverage through the month the child turns age 1 provided the requirements below are met.

The child must live with the mother to receive continuous coverage under this provision. This would include periods of temporary absence as defined in

^2140^. However, in joint custody situations, the child will only be eligible during the period of time he or she resides with the mother. No other eligibility factors must be met except for the fact that the child must be a citizen and a resident of the state. A loss of contact per ^7230^ shall not effect ongoing eligibility. Cooperation regarding countable income is not a requirement since changes in income do not affect newborn eligibility.

Newborn eligibility shall be provided if eligibility for the mother is established for any of the months in the prior medical period. However, if there is a break in assistance of one or more months during the continuous eligibility period, continuous eligibility shall end and the child would have to qualify under the poverty level program again or another medical program. In addition, if continuous eligibility is not established for the month following the month regular eligibility is lost, it cannot be provided and the child would one again have to qualify for poverty level coverage or another medical program, except as noted in ^2230^ regarding TransMed benefits. See Policy Memo 00-04-02 for treatment of newborns born to mothers in foster care.

NOTE: Children born to women who are only eligible for emergency services in the month of birth under the provisions of KEESM 2691 do not qualify for newborn eligibility. The children may however qualify for medical assistance under another program.

02330 **Inpatient Care for MCD Children -** Eligibility for children may end in either the calendar month the child turns age 1 or age 6 based on the differing poverty level determinations. However, if the child is receiving inpatient services in the month he or she turns age 1 or 6, Medicaid eligibility shall continue through the calendar month in which the inpatient care ends provided the child is or will be a Medicaid recipient in the month he or she turns such age (including prior eligibility). This provision would not be applicable to a child turning age 1 who continues to be eligible using the 133% poverty guideline for children ages 1 to 6 or turning age 6 who continue to be eligible using the 100% poverty guideline for children ages 6 and above. It also does not apply to long term care treatment and, thus, if the child's inpatient stay will exceed the month following the month of entrance, there is no continued poverty level eligibility beyond the month the client turns age 1 or 6. Instead, eligibility would be determined using long term care methodologies. The extended eligibility period is applicable not only to children who were poverty level program recipients in the month they turned age 1 or 6, but also to children who were eligible under another Medicaid program that month and lost that eligibility due to a change in circumstances (e.g., loss of cash eligibility). All general eligibility factors must continue to eligibility would continue to be determined based on the poverty level program rules.

02340 **Changes in MCD Family Unit -**

2341 Changes in MCD Family Unit - The following provisions apply in determining the continuous eligibility period for children when household composition changes.

2341.01 Removing a Child from an Existing Plan - When an eligible child in a current continuous eligibility period leaves the household, the continuous eligibility period shall not be broken as long as the new family is cooperating with the agency in adding the child to the new plan (see ^2341.02^). To facilitate the process, the child shall remain a participating member of the plan through the end of the month following the month the change is reported. This is not necessary if action is being taken immediately to add the child to the new case so no break in assistance results. Follow the provisions of ^2312^ when removing a child if the continuous eligibility period for a child is broken.

2341.02 Adding a Child to a Plan - A child meeting the general eligibility requirements of ^2272^ and ^2273^ or ^2402^ and ^2403^ may be added to a plan effective the month the request is made for coverage. If needed, eligibility may also be determined for three months prior to the month of request. (See also ^3110^ - Assistance Planning and ^2010^ - Act in Own Behalf). The following guidelines shall be used when making such changes:

(1) - Adding a Child to an Existing Plan - A new or recipient child may be added to an existing MP plan without a formal review. This includes children new to the household as well as children previously excluded from the plan because coverage was not requested (see ^3112^) and children previously ineligible due to nonfinancial criteria (e.g., the expiration of a crowd out penalty). A verbal request is sufficient to prompt such action.

(a) If a child is a recipient under the MP or Family Medical programs (including eligibility in another plan) and a request is made to add the child to a current MP plan, the child shall be added to the new plan effective the month following termination on the previous plan. A new determination of eligibility shall be completed based on the new family's circumstances to determine the type of coverage the child will have. Income in the amount already budgeted for the family unit on the medical program shall be used. However, the

income and needs of any new legally responsible persons added to the plan because of the addition of this child shall not be considered in the determination, as the child is continuously eligible through the end of the new family's continuous eligibility period. Changes in the type of coverage (Medicaid or HealthWave) may result. However, coverage shall continue, under the type of coverage initially established, through the end of the family continuous period if the child fails to meet financial criteria in the new household. A full redetermination which includes consideration of the income of any legally responsible persons, shall be completed at the next scheduled review.

(b) If the child is not a current MP or Family Medical recipient, the child is added effective the month of request. The income and needs of any new legally responsible person(s) added to the plan due to the addition of this child must also be considered in the determination for this child. Income currently budgeted on the case shall be used to determine eligibility for the child in the plan. If the child falls into the HealthWave income range, the additional HealthWave requirements of Health Insurance Coverage (^2411^) and State Employee Status (^2420^) must also be met. If retroactive coverage is requested, a child may be added to a plan up to three months prior to the month of request. Income currently budgeted for individuals already included in the plan shall be used to determine eligibility, including eligibility for months prior to the month of request. Changes in the type of coverage (Medicaid or HealthWave) may result. However, coverage shall continue, under the type of coverage initially established, through the end of the child’s initial continuous eligibility period if the child fails to meet financial criteria in the new household.

In either situation, if the family report a change in income that will potentially decrease the amount of premium obligation or status, the new income amount will be budgeted effective the month after the month the request is made for the new child.

(2) - Adding a Child to a New Plan - If a request for coverage is made by a new caretaker for a child who is a current recipient under the MP or Family Medical programs, and the family unit does not have an active MP program, a review application shall be obtained. See ^2460.01^ for requirements to remove a child from the previous case. It the family cooperates with the review process and the child remains eligible, a new twelve month continuous eligibility period is established. However, if the

family does not cooperate (e.g., fails to provide income information) or if the child is no longer eligible, the child remains eligible through the end of his/her initial continuous eligibility period under the same coverage initially provided. When processing such changes, it is imperative that action be taken as expeditiously as possible to ensure uninterrupted medical coverage. The case must be processed by first medical card cutoff in the month coverage terminates to provide for ongoing coverage. If coverage is authorized on or before the last day of the month coverage ends, a HealthWave Change Request Form shall be sent to provide coverage for the following month. However, if coverage is authorized after this day, a gap in coverage will result as a HealthWave Change Request Form is not appropriate.

Determinations for children impacted when two households combine because of the request for assistance of a mutual child shall also be treated according to these provisions (e.g., the birth of a baby combines two plans previously carried on separate case numbers).

02350 Medical Coverage Related to MCD Children and PW's -

2351 Medical Coverage Related to MCD Children and Pregnant Women (MA) - Medical assistance is available for children and pregnant women who are not financially eligible for Family Medical coverage (MA CM, TransMed or Extended Medical) or SSI and do not meet the Medicaid poverty level criteria. (See ^2271^.) Eligibility shall always be determined first for the Medicaid poverty level programs prior to an MA determination.

2352 MA - This program covers children who meet the Family Medical eligibility factors. There is, however, no coverage for parents or other caretakers of the child under the MA program. To receive medical assistance they would have to qualify under another Medicaid program (e.g., MP or MA PW for pregnant women, MS for disabled or aged individuals, etc.).

NOTE: The continuous eligibility provisions of ^2301^, ^2311^, and ^2320^ are applicable to pregnant women and children who lose eligibility for Family Medical coverage due to excess income unless eligible for continued medical coverage under the TransMed provisions of ^2230^ or 4 month extended medical provisions of ^2271^. Should TransMed or 4 month extended eligibility cease prior to the end of the continuous eligibility period, the provisions of ^2301^, ^2311^, and

^2320^ shall be reinstated.

The following requirements must be met.

2352.01 Age - The person must be under the age of 19.

2352.02 Income and Resource Methodologies - The income methodologies of ^4000^ are to be used in determining eligibility for this group. There is no resource requirement unless a nonexempt trust exits (see KEESM 5130). The protected income level is based on the number of eligible persons in the plan and any legally responsible persons (except for SSI recipients) in the family group. Expenses for medical services paid or incurred by the eligible persons or legally responsible family group member are allowable in determining eligibility. (See ^6500^)

2353 Pregnant Women (MA PW) - The pregnant woman portion of the MA program is intended to cover pregnant women who are not financially eligible for Family Medical or under the poverty level program. There is no medical eligibility for the father of the unborn child unless he qualifies for Medicaid in his own right.

The following requirements must be met:

2353.01 Pregnant - The woman must be medically determined to be pregnant.

2353.02 Income and Resource Methodologies - The income methodologies of ^4000^ are to be used in determining eligibility for this group. There is no resource requirement unless a nonexempt trust exits (see KEESM 5130). The needs and income of the woman, unborn child, and the father of the unborn child, if in the home, must be considered. The protected income level is based on the above individuals. In addition, expenses for medical services paid for or incurred by the pregnant woman and any of the above persons are allowable in determining eligibility. (See ^2430^)

2353.03 Postpartum Medical Coverage - Eligibility as a pregnant woman ends 2 months following the month of birth of the child or termination of pregnancy provided that the woman was accurately receiving FFP medical the month of birth or pregnancy termination (including prior eligibility).

All general eligibility factors must be met during the extended coverage period. Financial eligibility would continue to be determined as though the woman was still pregnant. Thus, the needs of those persons who would be reflected in the determination while the woman was pregnant would be reflected in the extended period (i.e., the pregnant woman, unborn child, and father, if in the home).

02360 Breast and Cervical Cancer - Refer to KEESM 2693

02400 General Program Information for Title XXI - The HealthWave program is designed to cover children up to age 19 who are not financially eligible for Medicaid and whose countable income does not exceed 200% of the federal poverty level. The child must not be covered under current health insurance nor have access to such coverage if the custodial parent is a state employee. If family income is equal to or greater than 151% of the federal poverty level, a monthly family premium is charged for coverage.

HealthWave is based on a federal block grant authorized under Title XXI of the Social Security Act. For the most part it is state controlled but is subject to federal funding allotments as well as state funding provided by the Kansas State Legislature through SRS.

The HealthWave program provides health coverage through a network of managed care entities. A capitated payment rate is established by the Division of Health Care Policy on a per enrollee basis. The overall scope of services covered in the program is similar to those services provided in the Medicaid program. Both the local SRS offices and the Central HealthWave Clearinghouse share the responsibility for establishing eligibility based on policies established within the limits set forth in state and federal statutes, the Code of Federal Regulations, and the Kansas Administrative Regulations.

Children who are eligible for Medicaid (SI, poverty level eligibles, etc.) do not qualify for HealthWave and thus a determination of Medicaid eligibility must be done prior to establishing coverage under HealthWave. This includes a spenddown determination (MA or MS) if beneficial to the child.

Coverage under the HealthWave program is not effective until the child is enrolled in one of the applicable managed care plans. See ^2470^. HealthWave is not an entitlement program like Medicaid and coverage availability is subject to federal funding authorized for the program.

The following additional requirements and issues affect the HealthWave

program.

2401 General Eligibility Requirements - The general eligibility requirements of acting in own behalf ^2010^ (including the caretaker requirements in ^2110^), cooperation ^2020^, citizenship and alienage ^2040^, and residence ^2050^ must be met.

2402 Age - The child must be under the age of 19. Coverage may be provided through the end of the month of the individual's 19th birthday.

2403 State Psychiatric Hospitals - HealthWave XXI coverage continues through out the month of entrance and the following month, regardless of the anticipated length of stay. HealthWave XXI coverage terminates at the end of this period and any continuing eligibility is determined under the Medicaid program. No patient liability is determined during this period, however, any premium obligation continues.

02410 Health Insurance Coverage for Title XXI -

2411 Health Insurance Coverage - Current health insurance coverage as well as termination of such coverage can impact eligibility as noted below.

2412 Uninsured Status - Each child must not be covered by comprehensive health insurance which includes coverage of at least doctor visits and hospitalization. This is regardless of the extent of coverage for these benefits, the cost of the insurance, the amount of any deductibles or co-insurance, or whether the maximum level of benefits for a particular coverage year has been reached. Health insurance coverage shall be deemed not to exist if the lifetime maximum of benefits for the policy has been reached.

Health insurance providing only single types of coverage would be excluded from this definition. Examples of health insurance which would not disqualify a child include:

2412.01 - Dental or vision only coverage.

2412.02 - Prescription only coverage.

2412.03 - Long term care insurance.

In addition, comprehensive health insurance that is not reasonably accessible to a child because of the distance involved in traveling to participating providers shall also be excluded from this definition. These situations generally involve insurance coverage through a Health Maintenance Organization that pays for services performed by a limited group of contracted providers. For example, a child is covered under a policy provided by an absent parent who lives in Florida. Although mail order prescription drugs are available and accessible to the child under the plan, the only participating doctors and hospitals are located in the state of Florida. Therefore, comprehensive coverage is not accessible and HealthWave coverage would not be denied for this child due to insurance coverage. These situations shall be evaluated on a case by case basis however, any situation where routine travel exceeding 50 miles one-way may be evaluated for exclusion under this provision.

If health coverage is obtained while an application for HealthWave is still pending, the insurance would be considered for eligibility purposes. If this is obtained after HealthWave benefits have been approved, even if enrollment with a HealthWave managed care provider has not yet occurred, eligibility shall continue for the entire continuous eligibility period (see ^2450^ below) and then terminated if health insurance is still in effect. The same is true if the insurance was present at the time the HealthWave benefits are approved but due to a waiting period, the coverage had not yet begun.

02420 **State Employee Status for Title XXI - State Employee Status** - A child whose custodial parent is a state employee and who has access to the State group health insurance plan for the children shall not be eligible for HealthWave coverage regardless of whether the coverage has actually been taken or when coverage becomes effective (for new employees). This is not applicable to 18 year olds unless the 18 year old or his or her spouse is a state employee. As noted in ^2412^, it does not matter whether the family can afford the coverage, access to the insurance is what results in ineligibility. This eliminates HealthWave coverage for children of most Kansas State employees and would also eliminate coverage for children of employees of any other states, including Missouri, Nebraska, Oklahoma, and Colorado. Children of most employees of Unified School Districts, other educational organizations, (such as community colleges) and some city and county offices in the state that have elected to participate in the State group health plan are also included in this exclusion and would not be eligible for HealthWave.

NOTE: Some part time and temporary state employees may not be eligible for state health insurance coverage. This will need to be verified before final action is taken. It is the custodial parent who must be the state employee and thus this prohibition is not applicable where only a stepparent, absent parent, or caretaker relative is the employee.

02430 **Ineligibility for Medicaid** - The family does not have the choice between Medicaid and HealthWave benefits. If the child is eligible for Medicaid, including coverage through the poverty level, Family Medical, (MA CM, TransMed or Extended Medical), MA, or MS programs), coverage must be provided under that program. This also includes pregnant woman coverage if the child is pregnant. See ^2510^.

However, a spenddown determination is only required if the family requests such a determination for either the prior or current period.

For a child that would be otherwise eligible for HealthWave, if there are expenses in the month of application as well as potentially past due and owing expenses which could be used to meet a current spenddown, the family can also be given the opportunity to qualify under the spenddown program (including both MA and MS). If requested, a full 6 month determination would be applicable. If the family can meet the spenddown and it is to their benefit to do so, Medicaid eligibility would be initially established on the case.

The Medical Expense Supplement (IM-3105.5) shall be used to obtain medical expenses if a request is made through the HealthWave application as well as information concerning resources which is needed for a spenddown determination. The family will need to be contacted to discern if there is a potential for spenddown coverage and the degree to which it will benefit the children. A final HealthWave determination would not be made until the spenddown decision is made.

If spenddown coverage is not established, HealthWave coverage shall then be initiated. If spenddown coverage is established for the current period, only one 6-month base should be established with a review set at the end of that period to redetermine HealthWave eligibility and establish the 12 month continuous eligibility period. If spenddown can be met for more than 1 base period due to using older unpaid bills or current non-covered expenses, spenddown coverage is to be extended for as long as the family or child can meet the spenddown requirement.

Prior medical eligibility provisions currently in effect are applicable to any family seeking such coverage even though they may only be HealthWave eligible in the month of application or are not currently eligible for either Medicaid or HealthWave. Eligibility can be established either through a poverty level or spenddown determination for the prior 3 months.

02440 Premium Requirement for Title XXI -

2441 Premium Requirement - A monthly family premium will be charged for HealthWave coverage beginning at 151% of federal poverty. If the total countable income is less than this amount, there is no premium charge. If income is equal to or greater than 151% of poverty but less than 176% of poverty, a $20 monthly premium is charged. If income is greater than or equal to 176% of poverty, a $30 monthly premium is charged.

Only one premium per family is charged regardless of the number of HealthWave eligible children. The amount of premium shall be based on the highest poverty level percentage determined for the family.

Families that include participating American Indian/Alaska Native (AI/AN) children are not subject to the premium requirements. The classification of AI/AN is based on client statement and will require no further verification. The premium will be eliminated for the family unit in these situations.

The HealthWave Clearinghouse administers the premium payment system and is responsible for all necessary billing and tracking of payments as well as providing reports. The family will be billed monthly but premium collection shall not be enforced until a review is completed. At that time any premiums due and owing must be paid in full or the HealthWave eligible children cannot receive further assistance. Such children can also not re-qualify for the program at a later date until any delinquent premiums are paid provided the children continue to live in the family unit upon which the premium was assigned (i.e., the case number in which the premium was assigned). This includes HealthWave children who, based on the yearly review, would be eligible for premium free coverage in the next review period. However, as Medicaid eligibility is not affected by non-payment of premiums, any Medicaid eligible child in the family would still qualify even if there are premiums due and owing from a period in which they were HealthWave eligible.

If a case with overdue premiums that are reflected on the Premium Billing History Report is authorized in error at the time of review, coverage shall remain in effect through the month following the month of discovery to give the client the opportunity to provide payment of the past due amount from the prior period. Upon discovery, notification shall be provided to the family informing them of case closure unless the past due amount is paid in full. The family is responsible for notifying the agency that payment has been made. The premiums must be paid,

notification to the Case Manager must be made and the case must be reauthorized by the first medical card cutoff for the second month following the month of discovery, because the HealthWave Change Request Form process is NOT applicable in this situation, even if premiums are paid by the end of the month.

Monthly accountings of premium payments for each family will be provided. At the time of review, payments for a family must be up to date as of the last monthly statement available from the HealthWave Clearinghouse for eligibility to continue. Delinquent payments must be made even if the family is no longer subject to any further premium requirement except for Medicaid as indicated above.

Optional MP reviews occurring prior to the end of the continuous eligibility period when adding other programs to an existing case shall not be completed if due and owing premiums exist on the case. (See ^7442.01^.) However, if a required review occurs on a case prior to the end of the 12-month continuous eligibility period, any premiums not paid at that point must be made current before eligibility is allowed to continue. Payments should be made by mail and consumers are to be strongly encouraged to not make cash payments at the local SRS office.

If a change occurs during the 12-month continuous eligibility period that decreases the family's poverty level percentage (such as a change in countable income or household composition), action is to be taken to reduce or eliminate the premium as necessary. Any changes shall be made effective with the month following the month of change. However, HealthWave coverage will continue through the end of the continuous eligibility period, even if income falls into the Medicaid range. For example, if a child is being added to a case for June and this action results in a decrease of the premium currently required for the family, the decrease would take effect in July the month following the month the child begins to receive coverage. HealthWave coverage will continue.

02450 Continuous Eligibility for Title XXI -

2451 Continuous Eligibility - Once financial eligibility is established as of the date the case is processed, all eligible children in a family group shall be eligible for 12 month period (see ^3110^ for Assistance Planning). If a household contains both Medicaid and HealthWave eligible children, the continuous eligibility period for the Medicaid eligible children shall be extended beyond the 12 months to provide for a family continuous eligibility period. Children who subsequently enter a household, request assistance and are determined eligible for

HealthWave or Medicaid shall remain eligible through the family's established continuous eligibility period. Newborns eligible under the provisions of ^2311^ and pregnant women eligible under the provisions of ^2300^ shall have continuous eligibility periods established independent of the family continuous eligibility period, as the periods established for these groups take precedence for these individual family members.

When a family contains individuals eligible under any combination of poverty level children, HealthWave, newborn or pregnant women categories, individual continuous eligibility periods may differ. When this occurs, the family continuous eligibility period is established by the continuous eligibility period of the non-pregnant/non-newborn children. If the plan contains only pregnant women and/or newborns the continuous eligibility date of these individuals will determine the family continuous eligibility period, in that order.

2452 Continuous Eligibility Period - Continuous eligibility begins with the month following month in which action is taken to approve coverage. This will be the month after enrollment as described in ^2470^. Coverage continues regardless of any changes in income. A loss of contact per ^7230^ shall not effect eligibility. Such eligibility shall continue unless one of the following circumstances occurs:

2452.01 - the child turns age 19;

2452.02 - the child no longer meets residency requirements;

2452.03 - the child dies;

2452.04 - the child enters an institution or jail;

2452.05 - the child no longer lives with a caretaker who meets the criteria of ^2110^;

2452.06 - the child is found to not have been initially eligible;

2452.07 - the family fails to cooperate with any review required prior to the end of the 12 month period in accordance with ^7330^. Coverage is to continue during the period in which the review is completed as long as the family is cooperating;

2452.08 - the child becomes eligible for HCBS or for SSI (including eligibility under the protected class in KEESM 2639), foster care, or adoption support assistance;

2452.09 - there is a voluntary request for case closure.

In any of the above situations, coverage shall be terminated no later than the month following the month the circumstances occur allowing for timely and adequate notice except as noted. Continuous eligibility can be reestablished if circumstances change or a review completed and there has been less than a calendar month break in assistance. Otherwise, the child would have to qualify again for HealthWave or coverage under another medical program.

2453 New Continuous Eligibility Period - A new 12 month continuous eligibility period is established when one of the following occurs, even if there is a current period in effect:

2453.01 - at review per ^7330^ provided the family cooperates and remains financially eligible;

2453.02 - when a family becomes eligible for Family Medical coverage (MA CM, TransMed, or Extended medical benefits);

In addition to the above items, when an application is made for or a review occurs under another program (e.g., food stamp application or review) the application may be used to reestablish eligibility by completing a formal review of the MP program. In such an optional review is completed and the family cooperates and remains financially eligible, a new 12 month continuous eligibility period is established.

Although completing a review is not mandatory in these instances, each case situation shall be evaluated to determine if the family would benefit to complete the formal review. Factors to consider when making a decision include the potential of coverage changes in the future, tracking such changes and the administrative action required to ensure proper continuous eligibility is established. However, the ultimate decision will be based on whether it is in the family's best interest to complete the redetermination, which it will be in most situations.

For example, a family consisting of two Medicaid children with income at 80% of the poverty level applies for food stamps in

11-00. The family continuous eligibility period runs through 04-01. The family's income remains consistent with the amount previously budgeted for the MP determination. In this case, it is in the family's best interest to complete a redetermination of the medical program and extend the family's continuous eligibility period.

If the family remains eligible based on an application for other programs benefits or a review occurring prior to the end of a current 12 month continuous eligibility period, but the income determination results in a change in category from HealthWave to Medicaid or vice versa, the family shall continue HealthWave or Medicaid coverage until the end of the original continuous eligibility period. The new category would then be established for the remainder of the new continuous eligibility period.

All other changes are effective at the time of the next review including changes in income, age changes (excluding children turning age 19), a child becoming insured, or a child's parent becoming a State employee. In addition, closure of a TAF or FS case would not alter the continuous eligibility period. See ^2510^ for children who become pregnant.

02460 **Changes in the Family Unit for Title XXI** - The following provisions apply in determining the continuous eligibility period for children when household composition changes.

2460.01 **Removing a Child From an Existing Plan** - When an eligible child in a current continuous eligibility period leaves the household, the continuous eligibility period shall not be broken as long as the new family is cooperating with the agency in adding the child to the new plan (see ^2460.02^). To facilitate the process, the child shall remain a participating member of the plan through the end of the month following the month the change is reported. This is not necessary if action being taken immediately to add the child to the new case so no break in assistance results. Follow the provisions of ^2452^ when removing a child if the continuous eligibility period for a child is broken.

2460.02 **Adding a Child to a Plan** - A child meeting the general eligibility requirements of ^2272^ and ^2273^ or ^2402^ and ^2403^ may be added to a plan effective the month the request is made for coverage. If needed, eligibility may also be

determined for three months prior to the month of request. (See also ^3100^ - Assistance Planning and ^2010^ - Act in Own Behalf). The following guidelines shall be used when making such changes:

(1) - Adding a Child to an Existing Plan - A new or recipient child may be added to an existing MP plan without a formal review. This includes children new to the household as well as children previously excluded from the plan because coverage was not requested (see ^3112^) and children previously ineligible due to nonfinancial criteria. A verbal request is sufficient to prompt such action.

(a) If a child is a recipient under the MP, or Family Medical programs (including eligibility in another plan) and a request is made to add the child to a current MP plan, the child shall be added to the new plan effective the month following termination on the previous plan. A new determination of eligibility shall be completed based on the new family's circumstances to determine the type of coverage the child will have. Income in the amount already budgeted for the family unit on the medical program shall be used. However, the income and needs of any new legally responsible persons added to the plan because of the addition of this child shall not be considered in the determination, as the child is continuously eligible through the end of the new family's continuous eligibility period. Changes in the type of coverage (Medicaid or HealthWave) may result. However, coverage shall continue, under the type of coverage initially established, through the end of the family continuous period if the child fails to meet financial criteria in the new household. A full redetermination which includes consideration of the income of any legally responsible persons, shall be completed at the next scheduled review.

(b) If the child is not a current MP or Family Medical recipient, the child is added effective the month of request. The income and needs of any new legally responsible person(s) added to the plan due to the addition of this child must also be considered in the determination for this child. Income currently budgeted on the case shall be used to determine eligibility for the child in the plan. If the child falls into the HealthWave income range, the additional HealthWave requirements of Health Insurance Coverage (^2411^) and State Employee Status (^2420^) must also be met. If retroactive coverage is requested, a child may be added to a plan up to three months prior to the month of

request. Income currently budgeted on the case shall be used to determine eligibility for months prior to the month of request. Changes in the type of coverage (Medicaid or HealthWave) may result. However, coverage shall continue, under the type of coverage initially established, through the end of the child's initial continuous eligibility period if the child fails to meet financial criteria in the new household. In either situation, if the family report a change in income that will potentially decrease the amount of premium obligation or status, the new income amount will be budgeted effective the month after the month the request is made for the new child.

(2) - Adding a Child to a New Plan - If a request for coverage is made by a new caretaker for a child who is a current recipient under the MP, or Family Medical programs, and the family unit does not have an active MP program, a review application shall be obtained. See ^2460.01^ for requirements to remove a child from the previous case. It the family cooperates with the review process and the child remains eligible, a new twelve month continuous eligibility period is established. However, if the family does not cooperate (e.g., fails to provide income information) or if the child is no longer eligible, the child remains eligible through the end of his/her initial continuous eligibility period under the same coverage initially provided. When processing such changes, it is imperative that action be taken as expeditiously as possible to ensure uninterrupted medical coverage. The case must be processed by first medical card cutoff for the month following the month coverage terminates on the original case number to ensure ongoing coverage. If coverage is authorized on or before the last day of the month coverage ends, coverage is continuous and no additional action is necessary. However, if coverage is authorized after this day, a gap in coverage will result as a HealthWave Change Request Form is not appropriate.

Determinations for children impacted when two households combine because of the request for assistance of a mutual child shall also be treated according to these provisions (e.g., the birth of a baby combines two plans previously carried on separate case numbers).

02470 Other Issues - Other issues affecting HealthWave 21 include the following:

Effective Date of Coverage - In contrast to the Medicaid program where coverage generally begins as of the month of application, HealthWave coverage begins when the child is enrolled with one of the appropriate

HealthWave managed care provider networks. This occurs the day following the day in which action is taken to approve coverage. There is no prior medical eligibility in the HealthWave program so any coverage for months prior to the effective date of enrollment would have to be determined through the Medicaid program. Retroactive enrollment is allowed for certain newborns. See ^2500^.

The enrollment process is automated and will be administered by the HealthWave Clearinghouse.

A timely processed review will allow for continuation of coverage, including retroactive coverage in some instances. Timely processing occurs when a coverage indicator is received by the fiscal agent on or before the last working day of the month following the review month. Coverage will lapse for reviews processed after this date unless the review application was received on or before the last day of the month a review is due, in which case a HealthWave Change Request Form is needed.

02480 **Financial Methodologies for Title XXI** - Financial eligibility shall be determined based solely on income. Resources shall not be considered. The needs and income of the child and his or her natural or adoptive parents, if living together, are to be considered. See the assistance planning guidelines contained in ^3111^ and subsections.

Persons age 18 and persons under 18 who are capable of acting in their own behalf per the guidelines of ^2222^ shall have eligibility determined in a separate plan. A separate case shall be established in these instances. However, for an ongoing child who turns 18, action to set up a separate plan for the child is not required until the time of the next scheduled review.

For families in which there are both Medicaid poverty level and HealthWave eligible children, a single family determination is required. To be eligible, the total countable income must not exceed 200% of the federal poverty level guidelines. See the Standards section in the Appendix. A one month base period shall be used in accordance with ^6311^.

02500 - Newborn children who are not eligible under the provisions of ^2320^, shall have their eligibility determined in the following situations:

2501 - If a HealthWave (HW) XXI mother has a child, the child is eligible for HW XXI coverage effective the date of birth. For coverage to go back to the date of birth the agency must be notified of the birth prior to the last day of the third month following the month of birth. A Baby born to a HW XXI mother is not eligible for 12 months continuous coverage and eligibility will be reviewed at the time the annual review for the case is completed. If the newborn is ineligible at the review, coverage will end;

otherwise, the child will be covered under Title XIX or Title XXI, whichever is appropriate. A new application and/or review form is not needed to add the newborn to the case. No verification of the birth is needed to add the newborn, and client statement is acceptable. A loss of contact per ^7230^ will not affect ongoing eligibility. All other individuals already receiving medical coverage will remain enrolled in either HealthWave or Medicaid as before the addition of the newborn. If adding the newborn reduces or eliminates the premium, the change is effective the month following the month of birth.

2502 - A HealthWave Change Request Form is to be submitted at the time of the birth of a child meeting these provisions so that the child may be added to the managed care roster as quickly as possible, including any retroactive months. The referral is to contain the name of the child, client ID for child, case name, case number, and date of birth. If the MCO notifies the HealthWave Clearinghouse of the birth of a child, the Case Manager will subsequently be notified. If the child is born to a HealthWave XXI recipient mother, action shall be taken immediately to add the child to the case. This notification will contain all necessary information to add the baby.

2503 - An eligibility determination is required for all other newborns including newborns that have HealthWave XXI siblings. If the newborn is being added to a case with an open MP or MA CM program, the child shall be added according to ^2460.02^. If the request for coverage is received timely as outlined in ^6311^ and the newborn is determined to be HealthWave XXI eligible, the child shall be added according to ^2470^. No retroactive coverage is provided to a newborn eligible for HealthWave XXI unless the mother is already enrolled in HealthWave XXI. If adding the newborn to the HealthWave XXI case reduces or eliminates the premium, the change is effective the month following the month of birth. If there is no current open medical program for the family, a new application is needed.

02510 **Pregnant Women** - If a potentially HealthWave 21 eligible child is pregnant, a Medicaid pregnant woman determination is required in accordance with ^2271^. If the child does not meet these guidelines, she shall then have eligibility determined under HealthWave guidelines. If eligible only as a HealthWave child, a referral must be sent to the HealthWave Clearinghouse for cases maintained in the SRS offices to inform them of the pregnancy. This needs to be done as quickly as the information is known as the managed care capitation rates are higher for pregnant women. The referral needs to include the name of the pregnant child, client ID for child, case name, case number, and expected date of birth. See Policy Memo 99-10-12.

For children who meet the Medicaid pregnant women guidelines, eligibility will be reestablished at the end of the postpartum period in accordance with ^2301^.

If not eligible, no further assistance would be provided to her and the remaining children would continue eligible for the remainder of their current continuous eligible period.

For an ongoing HealthWave eligible child who becomes pregnant, the child would continue to be covered under the HealthWave program until the end of her continuous eligibility period. A Medicaid pregnant woman determination would be required at the time of the next review for the child and if eligible, coverage shifted to Medicaid.

02520 **Child Support Enforcement** - There is no requirement to refer a child eligible for HealthWave XXI to CSE or that the family cooperate in establishing paternity and support on behalf of the child. A family can voluntarily pursue paternity and support for any HealthWave XXI child where there are no Medicaid eligible siblings and should be directed to the local CSE staff if such a request is made. In these instances, a system generated referral shall not be used.

02530 **Third Party Resources** - A third party is an individual, institution, corporation, public or private agency (other than the applicant/ recipient or the Department of SRS) who is or may be liable to pay all or part of the medical costs of a recipient that otherwise would be paid through the medical program.

Individuals eligible for medical assistance will be informed that they have the responsibility to utilize all available medical resources and to inform the agency of any third parties which may have a legal obligation to assume responsibility for payment of any or all medical expenses. (Examples are Medicare and other health insurance.) Refer to ^2020^ for the eligibility factor related to cooperation and ^2540^ regarding cooperation with HIPPS.

Third party liability can be considered a resource to the applicant/ recipient in the sense that it is or may be available to meet particular medical expenses, but is not considered against allowable non-exempt resource standards. No one may be denied Medicaid because of an existing or potential third party resource or other medical resources. See ^2400^ regarding HealthWave eligibility. Payment for a particular covered service may be withheld pending a determination of failure to utilize other medical resources or an existing liable third party (e.g., Medicare extended care benefits for payment of adult care home costs). In addition, eligibility may be denied or terminated for failure to cooperate in identifying and pursuing third party resources in accordance with ^2020^ or in cooperation with the HIPPS process in accordance with ^2540^.

The Case Manager has the responsibility to:

2531 - Ascertain and document legal liabilities of third parties (e.g., private or group health insurance coverage, Medicare, VA, etc.) or of pending law suits which might establish such a liability.

NOTE: Once verified, all existing health insurance coverage must be notated in the MMIS system. Failure to do so can result in claims being paid incorrectly or in error. However, certain third party coverage such as Indian Health Services, VA, and Kansas Health Insurance Association coverage are not to be included on the TPL file.

2531.01 - Inform the Medical Subrogation Unit in writing of failure of Medicaid consumers to utilize such third party liability or of pending law suits, insurance settlements, etc. which might establish such liability. This is not applicable to HealthWave. The Medical Subrogation referral form (Injury) shall be used to notify the unit. (See the KEESM Appendix.)

2531.02 - Request assistance from Medical Subrogation Unit in writing to help obtain third party resource information from non-cooperative sources such as birth mothers, adoption agencies, or adoptive parents when a Medicaid or MediKan consumer is adopted. This is not applicable to HealthWave. The Medical Subrogation referral form (Adoption) shall be used for this purpose. (See KEESM Appendix.)

02540 Health Insurance Premium Payment System (HIPPS) - Based on federal law, States are permitted to purchase employer-based health insurance for all clients who have access to such coverage and if it is determined to be cost effective. This includes "COBRA" continuation coverage which allows for continued health insurance coverage through a person's former employer. If it is known such coverage exists for an individual, the case is to be referred as indicated in item ^2550^ below. This optional provision has been adopted in Kansas and applies to Medicaid clients except those eligible only under SOBRA provisions. It is not applicable to HealthWave. Thus all employed medical recipients are impacted including those in the medical only programs such as MA, TransMed, and the Medicaid poverty level programs. Families receiving coverage with HealthWave are not to be referred. In addition, the requirement also affects persons who are legally responsible for a recipient but who are not eligible or for whom assistance is not requested (i.e., a noneligible parent or spouse such as an excluded stepparent). It is not, however, applicable to absent parents currently providing coverage for their dependents. Establishment of medical coverage for these individuals is a function of CSE.

However, if there is coverage available, but the absent parent is not currently providing such coverage, the case should be referred the HIPPS unit.

Coverage can be purchased for nonlegally responsible family members (grandparents, aunts, uncles, etc.) if by doing so recipient family members can also be covered. This would be a voluntary action on the part of the person and is not an eligibility requirement. The individual does not need to be living in the same household as the recipient.

The purchase of group health insurance is to be determined as cost-effective if the cost of paying for such coverage is expected to be less than the person's or family's medical expenditures that would otherwise be paid by SRS. Where cost-effectiveness is shown, the individual is required to enroll for such coverage if he or she is an applicant/ recipient and the State would be responsible for paying the cost of the insurance for the client and all Medicaid/MediKan eligible family members, including the premiums, deductibles, co-insurance, and other cost-sharing obligations. In addition, when a non-eligible family member must be enrolled in the health plan in order for the client to receive coverage, the State must also pay the premiums for that member but no other cost-sharing expenses would be covered. Persons for whom coverage is purchased will continue to receive medical assistance as long as they remain eligible. HIPPS only provides for the establishment of third party resources.

The Health Insurance Premium Payment System has been developed jointly by SRS and the fiscal agent for Kansas. The fiscal agent has the primary responsibility for administering the project which includes gathering information from clients, employers, and insurance companies concerning availability and extent of health insurance coverage, determining cost-effectiveness, and payment of insurance costs.

This affects only employer-based plans and not other types of private or group insurance. The client must cooperate in providing information concerning potential health insurance coverage and in enrolling for such coverage if it is cost-effective. Failure to do so shall result in ineligibility as indicated below. Following is a description of the basic requirements.

Enrollment Process - Individuals eligible for HIPPS are part of the managed care population and will receive a HIPPS Information Form with the managed care enrollment packet. Individuals should fill out the form and return it to the address listed on the form to find out if they qualify for the program. Individuals may contact the HIPPS unit directly for more information about the program.

02550 **HIPPS Referral - Referral Process** - Staff should send HIPPS referrals in instances where SRS or contract staff become aware of a family where at least

one family member is working (or eligible for COBRA coverage) and has high medical expenses, a serious illness, and/or has an employer who offers low cost family coverage. In these instances, staff should fill out the Health Insurance Premium Payment Information Form and send it to the HIPPS Unit.

The form should be completed as thoroughly as possible by the Case Manager. It is not necessary to send the form to the client, but additional information not available on the Information Form may need to be obtained by the HIPPS unit, including information on pre-existing medical conditions. If information is known about such illnesses, a determination on the cost-effectiveness of the policy as described in item ^2560^ below can often be made quicker. The Specialist does not need to verify that coverage exists prior to sending in the HIPPS Information Form. The HIPPS unit will make a final determination on coverage availability. Referrals should be sent whenever an eligible individual or a legally responsible individual is employed. But no referral should be sent when it is known that coverage is not available (e.g., situations where the employment is part-time and the company only offers coverage to full-time employees.) Those persons whose only employment is in a sheltered workshop setting should not be referred unless it is known that health coverage may be available.

If the client is covered through a policy held by an absent parent, no referral should be sent. It is assumed that coverage for these children was established by CSE as part of a medical support order. However, if the health insurance is available through an absent parent, but the child is not enrolled, a HIPPS referral should be sent. The policy will be reviewed and, if determined cost-effective, eligible children will be enrolled. HIPPS staff will ensure that CSE has not established the policy as part of the medical support order by checking the TPL file prior to enrolling any child in coverage provided by an absent parent. If the agency is aware that the employed individual is not authorized to work in the country (according to INS) a referral shall not be made.
Failure to cooperate in providing information concerning the completion of the referral can lead to denial of eligibility as indicated in item ^2560^ below.

Once a completed referral is received by the fiscal agent from the individual or the Specialist and the availability of coverage is established, the fiscal agent contacts employers and insurance companies to determine cost, enrollment restrictions, restrictions on pre-existing conditions, etc. This information will be used to determine cost-effectiveness. Special forms have been developed to gather this information and it is likely that it could take a maximum of 90 days to complete. If any additional information is needed, local staff may be contacted. Otherwise, staff will receive no additional feedback.

NOTE: Those persons whose only employment is in a sheltered workshop setting should not be referred unless it is known that health coverage may be available.

02560 HIPPS Cost Effectiveness - Cost Effectiveness Determination - Upon receipt of all information from the client, employer, and insurance company, the fiscal agent will determine if there is a likelihood that paying for the coverage would be cost-effective to the agency. This will be based on specific criteria which will analyze such things as the type of coverage available, the total cost of that coverage including all cost-sharing requirements, and any waiting period restrictions along with limitations on pre-existing medical conditions. This will then be compared with the historical claims data on a sample group which have like characteristics such as age, sex, type of coverage, etc. In addition, any medical expenses associated with known pre-existing and chronic illnesses are factored in. Based on this analysis, including both automated and manual procedures conducted by the HIPPS Unit, the coverage will be either approved or denied for health insurance purchase.

The client as well as the Case Manager, will be informed of the results by the HIPPS Unit. A copy of the approval or denial letter to the client will be provided to the Case Manager to include in the case file. On-line screens in the MMIS system are also available to provide this information. (See the SRS/MMIS User Reference for Field Staff Manual.)

The employer will be notified of an approval only when enrollment needs to take place or payment will be made directly to the employer. The insurance company would also be notified of an approval if payment will be made directly to the company. If denied, the employer and/or insurance company will only be notified if there was a reevaluation of a policy currently being paid that will be discontinued.

Once cost-effectiveness has been determined it will not be reevaluated unless there are changes in circumstances. This would include such things as loss of eligibility, loss or change in employment, change in the health insurance plans offered or in the cost, and changes in family composition. The HIPPS Change Report Form should be used to communicate any such changes in insurance/employment status to the fiscal agent as they become known.

If a person does not initially meet cost-effectiveness guidelines and staff become aware of changes in his or her situations that might lead to a different decision, a new referral should be sent to the fiscal agent for a new determination. The form should indicate that is a redetermination and what the event was that changed in the specified section of this form.

02570 HIPPS Payment Process -

2571 Payment Process - As noted above, if the health insurance coverage is determined to be cost effective, the client will be notified of the decision

along with the employer and/or insurance company. If the individual is not currently enrolled in the health plan, he or she is required to complete that process. As indicated previously, the client must enroll as a condition of eligibility. Failure to do so would result in ineligibility for only the affected client. See item ^2560^ below. The fiscal agent will inform field staff if the individual has failed to cooperate around the enrollment process so that negative action can be taken.

Once the enrollment process is complete, the payment process will be determined. Payment will only be made starting with the month of enrollment, not for any prior months. The primary payment issue will be concerning the premiums since all cost-sharing charges will be handled through the normal claims process. All coverage that is purchased for an individual or family will be automatically entered into the TPR files at by the fiscal agent.

2572 **Payment of Premiums** - Premiums will likely be paid directly to the employer or insurance company so that the client will not be directly involved. However, there will be some instances in which such an arrangement cannot be made, such as when the employer requires that coverage be paid for only through a payroll deduction. In these instances, the fiscal agent will have to arrange for a direct reimbursement check to the client. A process has been established to provide such payments. These would be made in a timely fashion as soon after the payment has been made by the client as possible. This should generally be within two weeks' time at most. Such reimbursement checks would be exempt as income per ^5500^.

Verification of any payroll deduction will usually not be required of field staff as the fiscal agent will have this information at the time of enrollment in order to begin making direct payments. Staff should reverify this information at the time of each review if there are no other changes in the interim. If the client must make other payment arrangements such as paying the insurance company directly, field staff will need to request verification from the client for reimbursement purposes. No reimbursement payment will be made without such verification.

Should the client discontinue the payroll deductions or other insurance payments, negative action would need to be taken to terminate eligibility for the individual. If the fiscal agent become aware of payments being discontinued or of enrollment being terminated, they will contact the Case Manager. If the Case Manager becomes aware of such instances, they are to refer the information to the fiscal agent immediately to stop reimbursement and take negative action as quickly as possible.

2573 **Termination of Payments** - As previously mentioned, there are a number of changes that could lead to the termination of premium payments. This would include changes in circumstances that result in loss of cost-effectiveness, elimination of coverage by the employer or insurance company, loss of eligibility or employment, change in employment, and disenrollment in the plan by the client. In all instances, payment will be stopped as soon as possible and the client will be notified of this by the HIPPS unit. Clients will be given as much advance notice as possible of the payment termination and they will be instructed to contact the employer or insurance company if they wish to retain coverage on their own.

Staff will receive copies of the termination notices sent for case file purposes. No further follow up action is required of staff other than to pursue any potential effects on eligibility as indicated in item ^2590^ below.

02580 **HIPPS With a Spenddown** - Treatment of Spenddown Cases. Coverage of health insurance cost under HIPPS will only be applicable to those persons who are eligible for medical assistance, other than the payment of premiums for non-eligible individuals as referred to earlier. As persons in spenddown status are not technically "eligible" for benefits until the spenddown is met, enrollment in and payment of employer insurance coverage under HIPPS would not be potentially applicable until the spenddown is met. In general, it is not expected that the majority of spenddown cases will meet cost-effectiveness criteria unless one or more of the family members has an ongoing chronic medical condition (such as AIDS, heart problems, cancer, etc.) and ongoing expenses arising from this condition that consistently meet spenddown.

If there is no indication of an ongoing condition or the likelihood of meeting spenddown, the information would not be referred. If, for instance, the only ongoing as well as projected medical cost for a family is the cost of employer health insurance they are already paying for, there would be no good reason to refer to the HIPPS project. These kind of cases would likely not meet cost-effectiveness criteria and, by picking up the cost of the family's premium, the family may no longer be able to meet spenddown.

In essence, this initial screening shall be regarded as a type of cost-effectiveness determination. It is applicable primarily to new applicants who have had no previous track record in terms of assistance or of having specific or ongoing medical needs. If, upon meeting spenddown for the first time, there appears to be the likelihood for additional medical expenses or recurring medical needs, the case is to be referred to the HIPPS Unit. Otherwise, the case should be reviewed again at the time of redetermination or at the time any medical change becomes known and a possible referral made at that time once spenddown has been met.

For ongoing cases, the same rules would generally apply when a client begins work. Once spenddown is met, the Case Manager specialist should briefly review the situation based on expenses presented and their knowledge of the recipient or family. If spenddown has been met for at least 2 base periods and there appears to be likelihood this will continue because of medical conditions, a referral should be sent to the HIPPS unit for processing. The HIPPS unit will then determine cost-effectiveness in these instances but not take action to begin enrollment and payment until spenddown is met as indicated above for applications.

02590 **HIPPS Eligibility - Impact on Eligibility** - As mentioned previously, the client must cooperate in providing information to complete the form as well as enrolling for and retaining employer health insurance coverage that has been determined cost-effective. Per ^2021.03^, failure to do so in either the cash or medical programs would result in ineligibility for the affected individual. That individual would be the person who is employed.

For MA CM purposes, if the individual is a parent or other caretaker, only that individual would be rendered ineligible. For all medical-only programs including SI, MA CM, and TransMed, only the individual would be ineligible.

There is a potential for good cause to be granted in some instances. As situations become known that may involve good cause, they are to be referred to the Area EES Field Administrator for consultation with EES and AMS central office staff.

02600 **Certificates of Creditable Coverage** - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that group health plans furnish certificates of creditable coverage whenever an individual's health coverage ceases. HIPAA lists Medicaid and most health insurance plans, as forms of creditable coverage. HealthWave is also considered creditable coverage. The purpose of the certificate is to document that the individual had prior health coverage and thus reduce or eliminate any preexisting condition exclusion under subsequent health benefit coverage the individual may obtain. As long as an individual's creditable coverage is not interrupted by a significant break (defined has a break of 63 or more full days where no creditable coverage exists), creditable coverage may be combined from different periods. A group health plan must reduce the length of any preexisting condition exclusion period they apply by the amount of the individual's creditable coverage. A coverage period of 18 months or more would eliminate any exclusion period.

Certificates of creditable coverage are issued to Medicaid recipients under any program, including those covered under the SOBRA provisions, those losing automatic medical coverage as a result of termination of cash assistance, and

persons terminated from TransMed. Certificate issuance is the responsibility of the Fiscal Agent. Certificates are sent out once a month to all individuals whose medical eligibility terminated the first day of the prior month. The certificate documents all periods of creditable coverage in the past 24 months. For spenddown consumers, only the base periods in which the spenddown is actually met are considered creditable and, in such instance, all six months are credited. Certificates are not sent to individuals with a date of death on file.

NOTE: Certificates for HealthWave eligible individuals will be the responsibility of the contracting HMO to issue.

Replacement certificates can be sent to individuals, employers or insurance companies upon request. These certificates are issued through the MMIS.

2610 Notice of Privacy Practice - The Health Insurance Portability and Accountability Act (HIPAA) also requires group health plans to provide a notice explaining the uses and disclosures of protected health information to participants in the plan. All health care assistance programs administered by SRS, including Medicaid, MediKan, HealthWave 21 as well as other state-funded groups (such as tuberculosis coverage) are considered group health plans for purposes of this requirement. The notice must also explain the legal duties and responsibilities of the agency and provide an explanation of the rights of the insured. The Notice of Privacy Practice (NOPP) is used for this purpose.

The NOPP must be sent to each household approved for health care coverage. An additional NOPP must be provided when a new participant is added to the plan, including newborns. Participants with a break in coverage of 12 months or more shall also be sent a new notice.

For additional information regarding the requirements of HIPAA, including an explanation of the referenced disclosure requirements or a definition of protected health information refer to Administrative Procedures Manual #1500. For a copy of the NOPP, see the KEESM Miscellaneous Forms Section.

03000: **Assistance Planning** -

03100 Assistance Planning for Medical Programs -

3110 - This section sets forth the assistance planning guidelines regarding persons who are in independent living arrangements. Persons in independent living are those who live in their own homes (renting, living with friends or relatives, homeless, etc.) or who live in room and

board situations or specialized living arrangements. It does not apply to persons in the home-and community-based services (HCBS) program.

Specialized living arrangements are defined as non-medical living arrangements which are publicly funded or funded by not-for-profit agencies and/or organizations which provide living arrangements for individuals or families having an identified physical, mental, or social condition that requires an element of care or supervision. This would include but is not limited to alcohol or drug abuse facilities licensed or certified by ADAS, living arrangements sponsored by community mental health centers or similar agencies, shelters for battered women, temporary shelters for the homeless, and other non-medical residential care facilities.

3111 **Assistance Planning** - Assistance planning relates to the consideration of certain individuals living together as a family group. A family group is defined as the client and all individuals living together in which there is a legal and/or a caretaker relationship. (See KEESM Appendix T-6 regarding the definition of a caretaker and a legally responsible relative, ^2140^ for temporary absences, and ^2069^ for paternity.)

For MA CM, the assistance plan shall be based on TAF rules (see KEESM 4100). However, persons excluded from the TAF assistance plan per KEESM 4113 because of a labor dispute, cash fraud conviction, time-limited assistance, fugitive felon or drug felon provisions are potentially eligible for Medicaid and are included in the MA CM plan. For all other programs the assistance plan shall consist of those persons in the family group for whom assistance is requested and any excluded legally responsible person.

3112 **Treatment of Assistance Plan** - As noted earlier, the assistance plan for all medical programs other than MA CM (e.g., Medicaid Poverty Level and HealthWave) shall consist of those persons in the family group for whom assistance is requested and any excluded legally responsible person for those individuals. A stepparent shall be excluded from the assistance plan if assistance is requested only for his or her stepchild. For pregnant women, the assistance plan shall consist of the woman, the unborn child, and the father of the unborn child if living together. In addition, if the pregnant woman is a minor, the assistance plan must include the parents if living together. For children in the Medicaid poverty level or HealthWave program, if assistance is requested for a child who is ineligible due to failure to meet eligibility criteria (citizenship, insurance, etc.), the child shall still be included in the assistance plan. This does not include children who fail to meet age criteria, who have entered an institution or jail, or who are eligible for

HCBS, SSI, TAF, foster care, or adoption support assistance. If the family fails to cooperate in providing information necessary to determine a child's eligibility, he or she would be excluded from the plan. The income, resources (if applicable), and medical expenses of all persons in the plan shall be considered and their needs reflected in the applicable income and resource standard.

The client may include or exclude any family group members for assistance purposes.

Except as noted below, eligibility shall generally be determined within a single assistance plan for those members who qualify under the same category of assistance. For example, if more than one member requests and is eligible for MS, a combined determination is required. This policy would also be applicable to members of a family who qualify for the same medical program but under different individual subtypes (i.e., MP, N2, N3, N4, T5, T6, or T7). Once again, a combined determination of these individuals would be required. For purposes of this provision, the Medicaid poverty level and HealthWave programs shall be viewed as the same category of assistance and a combined determination would be applicable.

Separate assistance plans shall be established in the following instances:

3112.01 - Each SSI recipient (including 1619b recipients) shall have a separate plan as well as any child whose needs are met through foster care or adoption support payment.

3112.02 - Family group members who qualify under different medical programs (e.g., Medicaid poverty level, etc.) shall have separate plans except for family groups where some children qualify for the Medicaid poverty level program and some for HealthWave as noted above.

3112.03 - Each client in a long term care arrangement shall have a separate plan.

3112.04 - Emancipated minors, minors determined to be able to act in their own behalf, and 18 year old children shall have separate assistance plans.

3112.05 - Any child (and his or her siblings) in the family who is not living with a legally responsible person (such as grandchildren, nieces and nephews, etc.) shall have a separate assistance plan.

3112.06 - If the only children for whom assistance is requested are stepsiblings or have no blood relation, a separate plan is required as only the income of each child's parent can be considered. Otherwise, where all siblings (excluding unborn siblings) are blood related or adoptive brothers and sisters, a single plan shall be applicable if they qualify under the same category of assistance. This would include family arrangements in which assistance is requested for the non-mutual children of a husband and wife and a mutual child.

03120 Additional Assistance Planning -

03121 Additional Assistance Planning Provisions - The following additional principles are applicable for assistance planning purposes:

3121.01 - The caretaker can qualify for medical benefits under the MA CM program.

3121.02 - A common-law marriage establishes legal responsibility provided the parties: have the legal capacity to enter into a marriage (meets the age criteria and is not already married to another individual); consider themselves presently married; and hold each other out as husband and wife to the public. The "Statement of Common-Law Marriage" form in KEESM Appendix section P-5 may be used to document this relationship. However, when completion of the form is requested, negative action for failure to complete it shall not be taken unless the marriage relationship affects the determination of eligibility or benefit amount.

3121.03 - Any individual who does not have the legal responsibility to support a person in need is not required to do so. When such individual in the household, including an SSI recipient, voluntarily and regularly contributes cash to the applicant/recipient toward household expenses (including his maintenance needs), the net amount of income realized by the household shall be considered. To determine the net amount of income to be counted, the difference in the PIL including the individual and the PIL excluding the individual shall be deducted from the gross amount of the contribution.

04000: **Resources** -

04010 - The maximum allowable nonexempt resources of all members of the assistance family group shall not exceed two thousand dollars ($2000) for one person and three thousand dollars ($3000) for two or more persons who are in the family group (excluding SSI recipients).

In determining MA eligibility, the $2000/$3000 standards are applicable where a countable trust arrangement exists in accordance KEESM 5620. For MA CM, a $2000 resource standard is applicable when a countable trust exists.

04020 Family Medical and Medicaid Provisions -

4021 Medicaid Provisions - A revocable or irrevocable trust shall be regarded as an available asset and/or income if the following conditions are met.

4021.01 - For revocable trusts, the value of the trust shall be considered a resource available to the client. Payments from the trust to or for the benefit of the client shall be considered as income.

4021.02 - For irrevocable trusts established by a client after August 10, 1993:

(1) - if there are any circumstances under which payment can be made to or for the benefit of the client, the portion of the trust from which payments can be made shall be considered an available resource. Payments made from the trust to or for the benefit of the client shall be considered as income. Payments made from the trust for any other purpose shall be considered under the transfer provisions of KEESM 5720.

(2) - If payment to the client cannot be made under any circumstances, the creation of the trust shall be considered as a transfer for less than fair market value under the provisions of KEESM 5720 based on the date of establishment of the trust or, if later, the date payment to the client was restricted or foreclosed. If only a portion of the trust is made unavailable in this way, that portion shall be regarded as a transfer.

A client shall be considered to have established a trust if assets of the client were used to form all or part of the trust and if established, other than by will, by the individual, the client's spouse, or any other person or entity, including a court or administrative body, with the legal authority to act for or on

behalf of the client or spouse or acting at the direction or upon request of such person. In addition, the provisions of this subsection apply without regard to the purposes for which the trust was established, whether the trustees have or exercise any discretion under the trust, any restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of distributions from the trust. If the trust includes assets of any other person or persons, these provisions shall apply only to the portion of the trust attributable to the assets of the individual.

4021.03 - For irrevocable trusts established with the client's own assets on or prior to August 10, 1993, the trust shall be considered available up to the maximum value of the funds which may be made available under the terms of the trust on behalf of the client if: (1) that client is a beneficiary; and (2) the trustees are permitted to exercise any discretion with respect to distribution to the client. The trust may be established by the client, the client's spouse, a legal guardian (including a parent), or a legal representative who is acting on behalf of the client. The amount from the trust that shall be considered as an available resource is the amount that could be distributed but was not within a base period (e.g., within a month for AM purposes or over a 6-month base period for MS cases). Any amount actually distributed shall be regarded as income. Any portion of the trust which is unavailable to the individual or which is not used for the benefit of the individual shall be considered a transfer of property for less than fair market value under the provisions of KEESM 5720.

NOTE: This provision shall not be applicable to trusts established prior to April 7, 1986 if the applicant/recipient is a mentally retarded individual who is residing in an intermediate care facility for the mentally retarded and the trust is solely for the benefit of the individual.

4021.04 - For all other irrevocable trusts not meeting the criteria of items ^4021.02^ and ^4021.03^ above (e.g., with no assets of the applicant/recipient such as a gifted trust or trust established by will), the trust shall be considered in terms of its availability to the individual per the guidelines of KEESM 5200.

04030 Exempted Trusts -

4030 Exempted Trusts - For trusts established after August 10, 1993, the

following shall not be considered available as a resource for purposes of determining eligibility.

4030.01 - A trust containing the assets of an individual under age 65 who meets the disability criteria of KEESM 2662 and which is established for the benefit of such individual by the individual's parent, grandparent, conservator, or legal guardian, or by a court. This exemption continues to apply even though the person reaches age 65 and older. As long as the trust was established before age 65, the exemption is applicable. A trust established by the disabled individual or his or her spouse is not exempt under this provision.

4030.02 - A trust containing the assets of an individual who meets the disability criteria of KEESM 2662 if such trust is established by a nonprofit association, a separate account is maintained for each beneficiary of the trust, and the trust is established solely for the benefit of the individual by the individual, parent, spouse, grandparent, legal guardian, or a court.

Payments made from such trusts shall also be exempt unless made available directly to the individual or to the individual's representative, including, but not limited to, a guardian, a conservator, representative payee, or person holding a power of attorney.

In the above instances, the trust must have a provision whereby any funds that remain in the trust upon the death of the client be provided to the State in an amount up to the amount of medical assistance paid out on that person's behalf. Otherwise, the trust must be considered. In the above instances, there are no exemptions applicable to trusts established on or prior to August 10, 1993 or to trusts established with assets other than the individual's.

4030.03 - A trust established as an Individual Development Account (IDA) for a TAF recipient or a participant in the Assets for Independence Demonstration Program (AFIA). See ^5500^ for the guidelines of an allowable IDA.

05000: **Income Guidelines** - There are two types of income, earned and unearned. Income shall include money received from such sources as wages, self-employment, property rentals, pensions, benefits, and contributions.

05100 - General Guidelines The following general rules are applicable:

5110 - Income must be real. To be real, income must be such that its value can be defined and measured.

5110.01 - Income value must be established by objective measurement.

5110.02 - Income shall be considered available when a client has a legal interest therein and the legal ability to make it available. Earned income is available to the individual producing it and all persons for whom he is legally responsible. Unearned income is available to the individual for whom it is intended and all persons for whom he is legally responsible.

5110.03 - The income of all persons whose needs are included in the medical assistance plan (including excluded mandatory filing unit members) must be considered. In addition, the income of all mandatory filing unit members who are excluded from the assistance plan in accordance with ^3100^ must be considered unless otherwise exempted. If, in the month of application, a mandatory filing unit person has left the home, his or her income shall not be considered as being available to the family in that month. Also see ^5500^.

5110.04 - The total income of husband and wife shall be considered in determining the eligibility of either or both for assistance if they are living together (including physical separation while maintaining a common life). This provision is not applicable for medical assistance when the husband and/or wife enter an institutional or HCBS arrangement. (See KEESM 8141, KEESM 8142(1), and KEESM 8143(1) and (2) for institutional arrangements and KEESM 8241, KEESM 8242(1) and KEESM 8243(1) and (2) for HCBS arrangements).

5110.05 - The income of an eligible or ineligible parent (excluding the stepparent for MP medical purposes) shall be considered in determining the eligibility of a minor child for assistance if the parent and child are living together. This includes the minor parent. This provision is not applicable to children in institutional or HCBS arrangements.

If a parent enters an institutional living arrangement (whether or not the facility is Medicaid approved) for other than a planned brief stay as defined in KEESM 8113, his or her

income shall be considered in determining the eligibility of a minor child only for the month the arrangement begins. Thereafter, only the minor child's income as well as any income contributed by that parent can be considered in determining the eligibility of that child. If the parent begins to receive HCBS, his or her income shall not be considered for the minor child beginning with the first month of services.

See KEESM 8243(2) regarding consideration of income upon discharge.

5110.06 - A conversion of property from one form to another shall not be considered as income except for the proceeds from a contract for the sale of property.

5110.07 - For Medicaid poverty level, if assistance is requested for a pregnant woman, eligibility is to be determined based on the income of the woman and the father of the unborn child if in the home. If the pregnant woman is a minor, the income of her parents, if in the home, must also be considered. (See ^2280^.)

For MA PW, both eligibility and spenddown must be determined based on the income of the pregnant woman and the father of the unborn child, if present. If the pregnant woman is a minor, the income of her parents, if in the home, must be also considered. (See ^2352.02^.)

05200 Unearned Income - Unearned income is any income that is not earned and may be derived from benefits (unemployment compensation, Social Security, VA, etc.), pensions, contributions, and settlements. Unearned income received or reasonably assured to be received in a month or in the eligibility base period shall be considered.

Gross unearned income shall be considered unless exempt as noted below.

Income producing costs can be deducted from gross unearned income to consider the net amount. This could include such things as property taxes and insurance payments on income producing equipment, vehicles, or property as well as interest paid on property purchased on an installment plan. It would not include such things as income taxes, garnishment, depreciation, or payments toward principal on property purchased on an installment plan. Also, see ^5413^ for guidelines in establishing such costs on unearned income arising from a self-employment enterprise. It is the responsibility of the client to provide verification for income producing costs. In allowing for such costs, it is not the intent of EES programs to pay debts, subsidize a nonprofit activity, or

treat income on the basis of IRS policies.

5210 Unearned Income Payments - Unearned Income Payments

5211 Regular Unearned Income - Regular unearned income shall be considered as income when it is reasonably assured to be available in the same monthly amount in the future. Regular unearned income shall be budgeted in accordance with ^6000^ and subsections.

5212 Irregular Unearned Income - Irregular unearned income results from income which varies in amount from month to month and is expected to continue. Irregular unearned income shall be budgeted in accordance with ^6000^ and subsections.

5213 Intermittent Unearned Income - Intermittent unearned income is received on other than a monthly basis such as quarterly, semiannually, or annually. It must be considered and averaged. (See ^6113^.) Intermittent unearned income received prior to the first eligibility period shall not be considered. The case record shall clearly indicate that the income is being treated as "intermittent" unearned income.

NOTE: An additional benefit check is provided on an annual basis to retired members of the Kansas Public Employer's Retirement System (KPERS) who began receiving a benefit prior to July 2, 1987. This 13th check is generally identical in amount to the monthly benefit. This check is to be treated as intermittent income and budgeted over the entire year by dividing by 12.

05300 Types of Countable Unearned Income -

5310 Annuities, Pensions - Annuities, pensions, retirement, veterans, or disability benefits, old-age, survivors, Social Security benefits, or strike benefits are countable. The amount of a VA benefit which has been augmented because of a dependent(s) (spouse and/or child) shall be regarded as income for the dependent, not the veteran. SSA benefits are considered the income of the person for whom they are intended.

5310.01 Child Support Current Support - Current support and/or alimony payments made directly to the household by nonhousehold members. Support and alimony payments are considered the income of the person for whom they are intended.

When child support and/or alimony are paid through the court, the gross amount before the fee is deducted is considered countable income. The amount of the fee is considered a household expense and is not to be excluded as income per ^5311^. See ^5500^ regarding the countability of child support arrearage payments.

5310.02 Worker's Compensation and Unemployment Insurance - The amount of Worker's Compensation payments awarded before attorney's fees are deducted is countable income. This is due to the fact that the portion that is an attorney's fee is considered a household expense and is not an allowable deduction from the income. Also refer to per ^5311^. Temporary worker's compensation is considered earned income. Refer to ^5400^.

The gross amount of unemployment compensation is countable income, even if some of the payment has been intercepted for child support purposes under the UI Intercept Program.

5310.03 Certain Reimbursements - The amount by which a reimbursement exceeds the actual incurred expense (when so indicated by either the household or the provider) shall be counted as unearned income. Reimbursements for normal living expenses are also considered income. See ^5500^.

5310.04 Trust Fund Income - Monies which are withdrawn or dividends which are or could be received by a household from trust funds considered to be exempted resources under KEESM 5430(1) or KEESM 5430(8) shall be considered income in the month received. Dividends which the household has the option of either receiving as income or reinvesting in the trust are to be considered income in the month they become available to the household, unless otherwise exempt under KEESM 5430(1) or KEESM 5430(8). Income producing costs shall be deducted from gross trust income to determine the countable amount. See ^5200^.

5310.05 Gambling Winnings - All winnings from such sources as bingo, lotteries, or racetracks are treated as unearned income in the month received. Gross amounts are counted even if taxes are taken out prior to paying the household. A gambling payoff that cannot be anticipated would not be counted for households in prospective budgeting.

5311 Vendor Income Not to be Exempted Income -

5311.01 - Monies that are legally obligated and otherwise payable to the household, but which are diverted by the provider of the payment to a third party for a household expense, shall be counted as income and not be exempted as a vendor payment. The distinction is whether the person or organization making the payment on behalf of the household is using funds that otherwise would have to be payable to the household. If an employer, agency, former spouse, or other person makes payments for household expenses to a third party from funds that are not owed to the household, these payments shall be excluded as vendor payments.

5311.02 Protective Public Assistance Payments - All or part of a public assistance grant which would normally be provided in a money payment to the household, but which is diverted to third parties or to a protective payee for purposes such as managing a household's expenses, shall be considered income to the household and not excluded as a vendor payment except as provided in ^5500^.

5311.03 Diverted Court-Ordered Payments - Money deducted or diverted from a court-ordered support or alimony payment (or other binding written support or alimony agreement) to a third party for a household expense, shall be considered income.

However, payments specified by the court order or other legally binding agreement to go directly to the third party rather than to the household, and support payments not required by a court order or other legally binding agreement (including payments in excess of the amount specified by a court order or written agreement) which are paid to a third party rather than the household, shall be excluded as a vendor payment even if the household agrees to the arrangement. This specifically applies to military retirement benefits where a court has ruled that a percentage of the payment must go to the ex-spouse as part of the divorce decree. Because this is part of the property settlement allowed by law, the ex-spouse's payments are not counted as income to the retiree since they are no longer legally obligated and otherwise payable to the retiree. See section (a) above for countable vendor payments.

5311.04 Money Withdrawn from an Individual Development Account (IDA) - Money withdrawn from an IDA and used for other than a qualified purpose (see ^5500^) shall be counted as unearned income in the month it is withdrawn.

5311.05 Others - Payments from government-sponsored programs, dividends, interests (that exceed $50.00 per month), royalties, monetary gifts (that exceeds $50 per month), gate money (money given to persons leaving prison), royalty payments made to tribal members from casino profits (also known as per capita income), and all other direct money payments from any source which can be construed to be a gain or benefit are counted in full.

See ^5500^ for exempt interest and for exempt monetary gifts.

05320 Contract Labor - Income earned from an employer, which forces the worker to absorb significant expenses in order to remain employed, is treated as self-employment income. These positions generally require the employee to enter into a contractual relationship with the employer. Examples of this type of employment would include a truck driver forced to purchase or lease his own truck or a rural mail carrier that must provide her own vehicle or pay all travel expenses, or an SRS Out-of Home relative child care provider. This would not apply to In-Home Child Care situations as with theses arrangements, the SRS parent is considered the employer of the childcare provider (relative or non-relative) coming into the child's home. The presence of additional expenses must be verified and documented. Such expenses must be directly related to the person's employment and required to maintain employment. Expenses cannot be reimbursed. Earnings dependent only upon typical deductions from income (such as state and federal taxes, OASDI, Medicare, and other mandatory or optional deductions) do not meet this criteria. In addition, persons required to incur only nominal expenses, such as mechanics required to purchase their own tools or regular postal employees required to purchase uniforms do not meet this criteria. These situations are to be evaluated on a case-by-case basis. The presence of a contract requiring the employee to provide equipment or cover costs necessary for employment is the primary indicator of income classified as contract labor.

05400 Earned Income - Earned income is income which is received as wages, salary, or profit resulting from the performance of services, including managerial responsibilities, by the recipient. Earned income may be derived from self-employment in the client's own business, or from wages or salary received as an employee including bonus pay received while an employee. Wages received from OJT are also to be considered as earned income, unless received by a TAF child who receives WIA (see ^5500^).

In addition, sick pay received for time off while working (i.e., short-term illness) shall be considered earned income when the person is still considered an employee by the employer and the person will be returning to work when recovered. This includes payments from temporary disability insurance in which the employer participates in the premium and temporary worker's compensation provided the individual is still considered an employee pending recuperation. If the person is not considered an employee while collecting the benefits (either sick pay or disability benefits), the benefits must be counted as unearned income per ^5200^.

Wages withheld by the employer to purchase benefits are counted as earnings in the pay period that the employee would have normally received them. Benefit "credits" offered in addition to wages which can be used to purchase benefits are not counted as income. If the employee does not use all of the credit to purchase benefits, and the employer pays the excess to the employee as part of their wages, the excess paid is counted as earned income.

05410 Types of Countable Earned Income -

5411 Regular Earned Income - Regular earned income results from earnings which are reasonably assured to be available in the same monthly amount in the future. (See 8300 and subsections for budgeting.)

5412 Irregular Earned Income - Irregular earned income results from earnings which vary in amount from month to month and are expected to continue. From a practical standpoint, irregular earnings result from full- or part-time employment when payment is received on any basis other than monthly or twice a month. (See 8300 and subsections for budgeting.)

5413 Self-Employment - Self-employment income is earned income received directly from one's own business, trade, or profession. Some guidelines to determine if an individual is self-employed include whether the person: (1) holds himself out as a business (e.g., advertises), (2) decides when and where to work, obtains own jobs or sales, and pays own expenses, has a risk of a profit or loss, and (4) pays his own FICA and income taxes (although this guideline, by itself, does not necessarily establish self-employment). The absence of one or more of these criteria indicate that the activity is not self- employment. Each situation must be evaluated on a case-by-case basis and documented in the case file as to whether a certain income is self-employment or not. An adjusted gross income amount must be determined by deducting income producing costs from the gross earnings.

5413.01 - Ownership of rental property and other income-producing personal property (other than cash assets) shall be considered a self-employment enterprise; however, income derived from the property shall be considered self-employment earned income only if a member of the household is actively engaged in the production of income and/or the management of the property at least an average of 20 hours per week. Otherwise it will be considered unearned income. See KEESM 5430 (12) regarding treatment of income producing property.

NOTE: Net countable income from this property, whether earned or unearned, shall be determined using the 25% standard deduction or actual expenses if requested. See 8403.01.

5413.02 - A loss from self-employment cannot be deducted from other income nor can a net loss of a business be considered as an income producing cost.

5413.03 - When at least one person has wages and at least one person is self-employed, separate calculations are required and the countable incomes are then totaled. Self-employment income shall be considered and averaged. (See 8403.)

5413.04 - Payments from a roomer or boarder shall be treated as though it were self- employed earned income. See 6213 for allowable cost of doing business (25% or actuals) for a roomer. Definitions of roomer and boarder are in the Appendix.

5413.05 - Payments to family or group day care providers through the Child Care Food Program, authorized by the National School Lunch Act shall be considered gross self-employment income from which the costs of doing business may be subtracted to determine net income. Included in the cost of doing business are the food expenses incurred by the day care providers to feed children under their care. Child care providers may also qualify to receive payments through this program for meals provided to their own children. These payments are also income from which the cost of providing meals may be deducted. The Child Care Food Program funds are administered by the State Department of Education and distribution to eligible day care providers is made through sponsoring organizations. Refer to the Appendix for the current list of sponsoring organizations.

5414 Intermittent Earned Income - Intermittent earned income is received on other than a monthly basis such as quarterly, semiannually, or annually. Such income is to be considered and averaged. Intermittent earned income received prior to the first eligibility period shall not be considered.

5415 Training Allowances and Payments - Training allowances and incentive payments and maintenance payments from vocational and rehabilitation programs recognized by federal, state, or local governments to the extent they are not a reimbursement are considered earned income. This includes wages earned through a job try out arranged through a CDC or through an industrial evaluation arranged through KETCH. See also 8135.

Maintenance payments made by Kansas Rehabilitation Services are considered a reimbursement and are thus exempt. See ^5500^.

Stipends to Native American which are intended to cover living expenses are also considered earned income.

5416 Wages Withheld/Salary Advances - Wages are sometimes paid in advance to an employee, usually at the request of the employee. Wage advances are not counted as income received. Repayment of those advances are not deducted from gross income, either.

However, wages held by the employer as a general practice, even if in violation of the law, shall not be counted as income to the household. For example, it is routine in many places of employment for the first week or two weeks of wages to be withheld and not paid until the following pay period. This is legal and the wages would not be counted until received.

5417 Income from Sale of Blood - Income derived from the sale of blood shall be treated as earned income.

5418 Garnished or Diverted Wages -

5418.01 - Available income shall not be reduced by wage earner plans, garnishments, income withholding orders and similar types of income reductions. Such forms of income withholdings are generally used to meet the individual's previous or ongoing obligations and are considered available for the purpose of determining cash and medical eligibility.

5418.02 - Wages earned by a household member that are garnished or diverted by an employer, and are paid to a third party for a household's expenses, such as rent or child support, shall be considered income. However, if the employer pays a household's rent directly to the landlord in addition to paying the household its regular wages, the rent payment shall be excluded as a vendor payment. In addition, if the employer provides housing to an employee, the value of the housing shall not be counted as income.

5419 Family Subsistence Supplemental Allowance (FSSA) - FSSA payments made by the military to certain members of the Armed Forces is considered earned income for all programs. This program was implemented May 1, 2001 and provides certain members of the Armed Forces with a special allowance to partially address the issue of enlisted members relying on food stamps to make ends meet. Qualifying members and their families are eligible for a cash allowance up to $500 per month. The law authorizing the program, Public Law 106-398, does not prohibit members from receiving FSSA benefits and food stamps at the same time. The amount of the FSSA will be shown on the member's Leave and Earnings statement.

05500 Exempt Income - Income from the following sources is exempt as income only in the month received or, where indicated.

5510 Reserved -

5511 Adoption Support, Foster Care and Permanent Guardian Subsidy - Adoption Support, Permanent Guardian Subsidy and Foster Care payments (including Independent Living payments) are exempt as income in the month received and as a resource in the following months. Also see ^2100^.

5512 Agent Orange - Settlement payments are exempt as income in the month received and as a resource in the following months.

5513 Alaska Native Claims - Distributions from Native Corporations formed pursuant to the Alaska Native Settlement Act including case (not in excess of $2000/year), stock, partnership interest, land or interest in land, and interest in settlement trust are exempt as income in the month received and as a resource in the following months.

5514 Aleut Income - Payments granted to certain eligible Aleuts under Title II of P.L.100-383 (enacted 8/10/88) is exempt as income in the month received and as a resource in the following months.

5515 Americorps - Any payments provided through AmeriCorps are exempt as income in the month received and as a resource in the following months.

5516 Assistance Payments - Retroactive assistance payments are exempt as income in the month paid and as a resource in only the following month.

5517 Charitable Donations - Any cash or in-kind donation based on need not to exceed $300 in any quarter starting in January, April, July or October which are received from one or more public or private nonprofit charitable organizations are exempt as income in the month received and as a resource in the following months. Amounts in excess of $300 shall be considered as countable unearned income.

5518 Child Care Payments - Made to persons other than a childcare provider are exempt as income in the month received.

5519 Child Support - Arrearage payments are exempt as income in the month received. (If an arrearage is owed, child support payments paid in excess of the current support obligation are considered an arrearage.)

NOTE: This exemption does not apply to arrearage payments paid for a child who is age 18 or over. These payments are not considered child support payments and are considered the income of the person receiving the payment.

5519.01 - Child support pass through payments are exempt as income in the month received.

5520 Children's Earnings - The earned income for a child who is an elementary or secondary school student (including GED) is exempt as income in the month received. The exclusion shall continue to apply during temporary vacation breaks, provided the child's enrollment will resume following the break. This exclusion does not apply to emancipated minors or to unemancipated minors determined able to act in own behalf per ^2011.02^.

5520.01 - For MA CM, this exemption applies to children under age 18 or age 19 if the child is working toward attainment of a high

school diploma or its equivalent. See ^2100^.

5520.02 - For all other Family Medical Programs, this exemption applies to children under age 18.

5520.03 - If the child's earnings or amount of work performed cannot be differentiated from that of other household members (Example: migrant farm workers), the total earnings shall be prorated equally among the working members of the household and the child's pro rata share excluded.

5520.04 - Once a student's income loses its exempt status per above, that earned income shall be countable effective with the income month following the month in which the income loses its exempt status.

5521 Crime Victims Fund - Payments made pursuant to the Crime Victims Fund (Public Law 103-322), as amended are exempt as income in the month received.

5522 Death Benefits - OASDI, VA, RR, or other burial benefits when used toward the cost of burial are exempt as income for the month received and as a resource in the following months.

5522.01 - Payments occasioned by the death of another person to the extent that the payments have been expended or committed to be expended for purposes of the deceased person's last illness and/or burial. Such payments include, but are not limited to, proceeds from a life insurance or burial insurance policy, gifts, and inheritances.

For the purposes of this provision, a person's last illness is defined as the illness that resulted in the person's death. Death resulting from injuries would not be considered in this definition. Medical expenses that can be reasonably attributed to the person's last illness shall be excluded in determining the amount of payment that is considered to be available. Documentation is required.

5523 Disaster Payments - Federal major disaster and emergency assistance and comparable disaster assistance provided by state or local government or by disaster assistance organizations in conjunction with a presidentially declared disaster are exempt as income in the month

received and as a resource in the following months.

This includes disaster unemployment assistance to an individual as a result of a major disaster. Individuals cannot be eligible for any other unemployment compensation and also receive disaster unemployment benefits. Payments are limited to 26 weeks. Central Office will notify the field if such disaster unemployment assistance is paid in Kansas due to a major disaster.

5524 **Donated Foods** - The value of the U.S. Department of Agriculture donated foods are exempt as income in the month received and as a resource in the following months.

5525 **Earned Income Tax Credits** - Earned income tax credits received either as a lump sum refund or on an ongoing basis are exempt as income in the month received and as a resource in the following months.

5526 **Educational Income** - Any bona fide grant, scholarship, loan or other money payment for educational purposes from any source including, but not limited to, PELL grants, SEOG's, GLS's, Carl D. Perkins Vocational ACT grants, college work study, grants or loans from civic organizations, Veterans Educational Income and private student loans from family or nonfamily members is exempt as income in the month received and as a resource in the following months.

Monies which are received as monthly living benefits from stipends or special programs such as Social Security to survivors based on educational participation, or to Native Americans through Tribal sources or Bureau of Indian Affairs shall not be exempt under this provision as they are not considered grants, loans or

5527 **Energy Assistance** - Payments or allowances made under some federal laws for the purpose of providing energy assistance are exempt from consideration as income in the month received. An example of such federal program is the Department of Health and Human Services' Low Income Energy Assistance Program (LIEAP).

Other home energy assistance furnished by a federal or state regulated entity whose revenues are primarily derived on a rate-of-return basis, by a private nonprofit organization, by a supplier of home heating oil or gas, or by a municipal utility company which provides home energy, if the assistance provided is based on need, is exempt as income in the month received.

5528 **Family Subsidy** - Payments provided through the Mental Health and Developmental Disabilities Commission or Family Support payments provided through the Children and Family Services Commission are exempt as income in the month received and as a resource in the following months.

5529 **Food Stamps** - value of the benefits issued under the current Food Stamp Act are exempt as income in the month received and as a resource in the following months.

5530 **Foster Grandparents** - Any payment provided to volunteers serving as foster grandparents is exempt as income in the month received and as a resource in the following months.

5531 **Gifts** - The first $50 (per case/per month) of irregular, occasional or unpredictable monetary gifts are exempt as income in the month received. Any amount in excess of $50 must be counted.

5532 **Holocaust Survivors** - Reparation payments made to Holocaust survivors are exempt as income in the month received. These payments shall also be exempt for purposes of determining patient liability in a long term care arrangement.

5533 **Hostile Fire Pay/Combat Pay** - Hostile fire pay (also known as combat pay) received while in active military service is exempt as income in the month received.

See Policy Memo #2005-03-03 Exclusion of Combat Pay for more detailed information.

5534 **Housing Assistance** - From federal housing programs including negative rent payments made to tenants of subsidized housing under HUD regulations is exempt as income in the month received and as a resource in the follow months.

5535 **Indian Monies** - Up to $2000 per calendar year of income received by individual Indians, which is derived from leases or other uses of individually-owned trusts or restricted lands pursuant to P. L 103-66 and P. L. 97-458 is exempt as income in the month received. For purposes of this provision, the exclusion of income shall be applied only to months for which an eligibility determination is being made. For income which is received monthly or more frequently, the exclusion shall be applied beginning with the first month of eligibility determination until the

$2000 limit is attained. For intermittent income situations, the income up to $2000 shall be subtracted from total intermittent income for the appropriate period with the remainder prorated to determine the countable monthly amount.

5535.01 Secretary of Interior - Any funds for an Indian tribe which are distributed or held in trust by the Secretary of the Interior (including Indian judgment funds), including interest and investment income accrued on money held in trust and initial purchases made with any funds distributed are exempt as income in the month received and as a resource in the following months.

Contact with the Bureau of Indian Affairs will be necessary to verify that the funds are exempted or are another type of benefits that must be counted as income.

5535.02 Aroostook Band - Payments granted to the Aroostook Band of Micmac Indians under Public Law 102-171 are exempt as income in the month received and as a resource in the following months.

5536 Individual Development Accounts - The interest on an allowable individual development account (IDA), including authorized matching contributions and accrued interest, is exempt as income as long as the account is maintained. For Working Healthy, income deposited into an IDA is also exempt in the month deposited. IDA's are exempt resources for all programs. An allowable IDA meets the following guidelines:

5536.01 - It is established by or on behalf of a TAF recipient or by or on behalf of an individual participating in the Assets for Independence Demonstration Program (AFIA) and is used for a qualified purpose.

5536.02 - A qualified purpose is one or more of the following:

(a) - post-secondary education expenses for college or vocational-technical school. Learning Quest or other 529 accounts are not considered IDA's;

(b) - first home purchase (must not have owned a home within three years of acquisition); or

(c) - business capitalization (business plan must be approved by

financial institution or non-profit loan fund).

NOTE: Any funds withdrawn from an IDA and used for any purpose other than one of those listed above shall count as unearned income in the month withdrawn.

5536.03 - The IDA must be a trust funded through periodic contributions by the establishing individual and may be matched by or through a qualified entity for a qualified purpose.

5536.04 - A qualified entity to match IDA funds for a TAF recipient is either a not-for-profit organization described in section 501(c)(3) of the IRS code of 1986 and exempt from taxation under section 501(a) or a state or local government agency acting in cooperation with a 501(c)(3) organization. For AFIA participants, matching contributions are made by the federal government through a grantee.

5536.05 - AFIA recipients may only contribute to IDAs with income derived from earnings.

Note: The earnings of an adult placed in an IDA are counted as earned income in the month earned.

5536.06 - Parents may establish IDAs for their children as well as for themselves. Children may also contribute their earnings to accounts established by or for them.

5537 In-Kind Income - Benefits are exempt as income in the month received

5538 Interest and Dividends - Interest income that does not exceed $50.00 per month is exempt as income in the month received. If in excess of that amount, the full interest shall be counted. Dividend Income: Dividends on credit union accounts are treated like interest income. Dividends earned on life insurance policies are exempt in full. Interest earned on additional insurance purchased with dividends is also exempt.

Unless specifically excluded, accrued interest and/or dividends are countable resources the month following the month of receipt.

5539 Interest to a Burial Fund - Interest credited to an exempted burial fund or to a prepaid burial space contract account is exempt as income in the

month received and as a resource in the following months. See KEESM 5430 (1)

5540 Japanese Aliens - Payments granted to certain United States citizens of Japanese ancestry and resident Japanese aliens under Title I of P.L. 100-383 (enacted 8-10-88) are exempt as income in the month received and as a resource in the following months.

5541 Loans - All loans, including loans from private individuals as well as commercial institutions, including deferred educational loans, shall be exempted from household income.

5541.01 - Monies received from reverse mortgages are treated as loans, even if payments are regular and predictable.

5541.02 - When verifying that income is exempt as a loan, a legally binding agreement is not required. A simple statement signed by both parties that indicates that the payment is a loan and must be repaid shall be sufficient verification. However, if the household receives payments on a recurrent or regular basis from the same source but claims the payments are loans, the provider of the loans may be required to sign a statement that indicates that repayments are being made or that payments will be made in accordance with an established repayment schedule.

5542 Lump Sums - Payments are exempt as income in the month received. A lump sum payment is defined as a nonrecurring one time payment that, if received regularly, would be non-exempt. Classification as a lump sum is dependent on its unpredictability either in amount or time of receipt that prohibits consideration as intermittent income. Lump sum payments may be from (but not limited to) the following sources:

5542.01 - Income tax refunds, rebates, or credits when paid as a lump sum benefit.

5542.02 - Other payments, such as retroactive cash assistance, unemployment compensation, Social Security, SSI, or railroad retirement benefits.

NOTE: Under PRWORA provisions, all retroactive SSI benefits in an amount that equals or exceeds 12 times the federal benefit rate paid to an eligible SSI individual generally must be paid in installments.

Such retroactive benefits will be paid in not more than 3 installments and the installment payments will be made at 6-month intervals. Since these installments replace what would have been paid as a single lump sum payment, these installment payments for retroactive SSI benefits are exempt as income.

NOTE: Regarding SSI Lump Sums: If SSA requires that the SSI lump sum be placed in a separate account, the entire amount of the lump sum shall be exempt, including any portion of the lump sum that is for the current income month.

5542.03 - Lump sum insurance benefit, including proceeds from crop insurance.

5542.04 - Refunds of security deposits on rental properties or utilities.

5542.05 - Bonus or severance pay paid in a lump sum after employment has been terminated.

5542.06 - Retroactive child support rebate payments including CSE checks (URA) received by the client while the TAF case is in open status.

5542.07 - VA pension benefit adjustments paid in a lump sum.

5542.08 - Lump sum child support arrearage payments. (If an arrearage is owed, child support payments paid in excess of the current support obligation are considered an arrearage.)

5542.09 - Excess insurance payments received through the Medicaid Program.

5543 Monies Withheld Voluntarily or Involuntarily - Monies withheld from assistance payments (e.g., TAF, GA, SSI) shall be included as countable income if the monies are withheld for the purpose of recovering from a household an overpayment which resulted from the household's fraudulent failure to comply with a state, federal, or federally-assisted program which provides assistance on the basis of financial need. (For a definition of "fraudulent," refer to ^8400^).

5543.01 - Mandatory deductions from military pay for educational

purposes shall not be included as income (or as a resource) while the individual is enlisted in the armed services. If individuals enroll in an educational institution after they leave the service, the amount withheld from salary plus any amounts matched from the VA will be treated as countable educational income minus expenses. Individuals who choose not to attend any school will receive the withheld monies in a lump sum payment and the payment shall be exempt per item ^5542^ above.

5543.02 - In addition, for all medical programs, programs not based on financial need that have a portion withheld to repay a prior overpayment received from that same income source, such as SSA, VA, Unemployment or Worker's Compensation shall not have the portion withheld counted as income.

5544 Older Americans Act - Payments received via the Community Services Employment Program funded under Title V of the Older Americans Act of 1965 (as amended by P.L. 100-175, the Older Americans Act Amendments of 1987) are exempt as income in the month received. Programs in Kansas funded under Title V include: Green Thumb, Project Ayuda (serving Wyandotte, Johnson, Douglas, and Shawnee counties), and the Senior Community Service Employment Program through the Midway Chapter of the American Red Cross (serving Sedgwick, Reno, Harper, Kingman, Butler, Cowley, Harvey, and Sumner counties).

5545 Radiation Exposure - Payments made pursuant to the Radiation Exposure Compensation Act, P.L. 101-426 (10-15-90) are exempt as income in the month received and as a resource in the following months. This law compensates individuals for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining in Arizona, Nevada and Utah.

5546 Rehabilitation Services Payments - Income directly provided by Kansas Rehabilitation Services, except as noted in ^5415^ is exempt as income in the month received and as a resource in the following months. Maintenance payments are also exempt as they are in excess of normal living expenses and are considered a reimbursement.

5547 Reimbursements - For out-of-pocket expenses are exempt as income in the month received and as a resource only in the following month.

Examples of exempt reimbursements are ones for job or training-related

expenses such as travel, perdiem, uniforms, and transportation to and from the job or training site. Reimbursements that are provided over and above the basic wages for these expenses are excluded; however, these expenses, if not reimbursed, are not otherwise deductible. Reimbursements for the travel expenses incurred by migrant workers are also excluded.

Also exempt are medical and dependent care reimbursements, reimbursements to students for specific education expenses such as travel or books, and jury duty payments.

To be exempt, these payments must be provided specifically for an identified expense other than normal living expenses and used for the purpose intended. When a reimbursement, including a flat allowance, covers multiple expenses, each expense does not have to be separately identified as long as none of the reimbursement covers normal living expenses.

5548 **Relocation Assistance** - Payments received under the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970 are exempt as income in the month received and as a resource in the following months. The applicant's or recipient's equity in a home is to be disregarded to the extent that such equity was purchased with payments under the Uniform Relocation Act of 1970.

5549 **Renal Dialysis** - Special incentive payments received for renal dialysis patients for care in their own home are exempt as income in the month received.

5550 **Repair or Replacement Payments** - Income from a one-time payment or a portion of a one-time payment from a settlement for repair or replacement of property or other settlement, including legal services and medical insurance payments, when the settlement is used for the intended purpose within 6 months of its receipt. This income is exempt as income in the month received and as a resource in the following 6 months.

5551 **Ricky Ray Hemophilia Act Fund** - Payments made pursuant to the Ricky Ray Hemophilia Relief Fund Act, P.L. 105-369 are exempt as income and as a resource for all programs. The payment is a one time amount of $100,000.

NOTE: Interest (that exceeds $50, see item ^5538^) earned on these exempt funds is not exempt as income.

5552 **SCORE or ACE** - Payments received through Service Corps of Retired Executives or Active Corps of Executives is exempt as income in the month received and as a resource in the following months.

5553 **Senior Community Service Employment Program** - Payments received through the Senior Community Service Employment Program are exempt as income in the month received.

5554 **Senior Health Aides** - Payments received through Senior Health Aides or Senior Companions are exempt in the month received and as a resource in the following months.

5555 **Shared Living** - In shared living arrangements; cash paid from one family to another toward the total cost of shelter is exempt as income in the month received.

5556 **Special Allowances** - Payments received as TAF special allowances are exempt as income in the month received. Examples of Special Allowances payments are special transportation payments and special service payments.

5557 **SSI** - Income of an SSI recipient (including 1619(b) recipients) and retroactive SSI benefits (even if the individual receiving the benefit is no longer an SSI recipient) are exempt as income in the month received. This does NOT apply to persons receiving long term care in Medicaid approved institutions as provided in KEESM 8112).

5558 **Susan Walker v. Bayer (MA & MP)** - Payments made pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation is exempt as income in the month received and as a resource in the following months. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Interest earned on retained funds is not excluded and is countable per item ^5538^. Accumulated interest is also countable as a resource beginning the month following the month of receipt, even if commingled with non-exempt funds.

5559 **Tax Refunds** - Legislated tax rebates and refunds are exempt as income in the month received.

5560 **Trust for a VA Child** - Money for a child which is held in trust by VA and determined by VA unavailable for subsistence needs is exempt as

income in the month received and as a resource in the following months.

5561 VA Payments - VA aid and attendance benefits and house bound allowance payments are exempt as income in the month received.

5561.01 - VA benefits resulting from unusual medical expense (UME) deductions are exempt as income in the month received.

5561.02 - VA benefits paid to children of Vietnam veterans who are born with spina bifida pursuant to Public Law 104-204 are exempt as income in the month received and as a resource the following months.

5561.03 - VA Benefits paid to children of women Vietnam veterans born with certain birth defects pursuant to Public Law 106-419 are exempt as income in the month received and as a resource the following months.

5562 Vendor Payments - Money payments that are not payable directly to a household but are paid to a third party for a household expense are vendor payments and exempted as follows:

5562.01 - A payment made in money on behalf of a household shall be considered a vendor payment whenever a person or organization outside of the household uses its own funds to make a direct payment to either the household's creditors or a person or organization providing a service to the household. For example, if a relative or friend, who is not a household member, pays the household's rent directly to the landlord, the payment is considered a vendor payment and is not counted as income to the household. Similarly, rent or mortgage payments, made to landlords or mortgagees by HUD or by state or local housing authorities, are other examples of vendor payments and are also exempted.

5562.02 - Cash assistance payments or other assistance payments financed by state or local funds which are not made directly to the household but paid to a third party on behalf of the household to pay a household expense shall be considered an exempt vendor payment and not counted as income to the household if such payments are for:

(1) Medical assistance;

(2) Child care assistance;

5562.03 - Housing assistance payments made to a third party on behalf of a household residing in temporary housing, if the temporary housing provided for the household lacks facilities for the preparation and cooking of hot meals or the refrigerated storage of food for home consumption.

5562.04 - Cash assistance payment or other assistance vendor payments financed by state or local funds which are made on behalf of migrants in the labor stream are exempt and not counted as income regardless of the purposes of the vendor payments.

5562.05 - Payments in money that are not made to a third party, but are made directly to the household, are counted as income and are not excludable as vendor payments.

5562.06 - Cash assistance payments or other assistance financed by state or local funds which are provided over and above the normal PA grant or other assistance payment and would not normally be provided in a money payment to the household shall be considered emergency or special assistance and exempted as income if provided directly to a third party for a household expense. This rule applies even if the household has the option of and receives a direct cash payment.

See ^5212^ for instructions on treatment of expenses covered by a vendor payment.

5563 **VISTA** - Is an AmeriCorps Program, any payments received through the VISTA program are exempt as income in the month received.

5564 **Work Employment Program Payments** - The values of any services or monies received for support or transitional services through work programs are exempt as income in the month received.

5565 **Workforce Investment Act (WIA)** - Income received from the Workforce Investment Act of 1998 (WIA) is exempt as income with the exception of on-the-job training program payments and paid work experience received by persons 19 or older. On-the-job payments and paid work experience received by persons under 19 are exempt as income.

5566 **Youth Service Corps** - Youth Service Corps - Payments provided through Youth Service Corps are exempt in the month received.

05580 **Treatment of Income and Deductions of Persons Not Included in the Assistance Plan** - (1) - Medical - The gross non-exempt earned and unearned income of legally responsible persons is counted.

(2) - Medical - All earned and unearned disregards and deductions are applicable to persons who are excluded from the assistance plan but whose income must be considered.

06000: **Budgeting of Income** - Income There are two types of income, earned and unearned. Income shall include money received from such sources as wages, self-employment, property rentals, pensions, benefits, and contributions.

06100 **Budgeting of Income** - A prospective (income estimate or conversion) or income average method of budgeting shall be used to determine eligibility and the amount of assistance. All income shall be counted in the calendar month received except when received on a twice a month or monthly basis. In such instances, income shall be viewed as being received by the client on the day that the payment is ordinarily scheduled.

NOTE: For teachers or other school employees, income shall normally be budgeted on a prospective basis as received unless the teacher has opted to receive their yearly contract salary over fewer than 12 months (such as only over 9 months during the school year). In such instances, the total year's income is to be averaged over 12 months so that a monthly amount of income is considered in determining eligibility and amount of assistance.

6110 **Prospective Budgeting** - Is based on an estimate reflecting the income received and/or expected to be received in the calendar month and the deductions which will be billed to the household in that month (see ^6220^ and subsections). The basis for any estimate (including tips) must be documented. For self-employment and other intermittent income and deductions, the estimate shall be determined as outlined in ^6200^. A prospectively estimated budget may be recomputed if information is received that the estimate is no longer correct (e.g., income that was estimated to be received in a month is reduced or terminated). The client must request a new budget computation and the change shall be applied to the case in a month subsequent to the month in which it is requested in accordance with provisions in ^6200^ and ^7212^.

Earned income information must be analyzed to accurately prospect income. Past information must be evaluated to determine if it represents the future. Paystubs provided must be evaluated to determine if any are not reflective of future earnings, such as a high check due to one-time overtime or a bonus, a low check due to illness or missed work, or a first partial check. If overtime, bonuses, or commissions are on the pay stub, these must be evaluated to determine whether this income is recurring. If the person is employed where tips are paid, it must be determined if tips are actual or allocated. (Certain employers must allocate tips if the percentage of tips reported by employees falls below a required minimum percentage of gross sales. To “allocate tips” means to assign an additional amount as tips to each employee whose reported tips are below the required percentage.) Pay information provided must be evaluated to determine if there was a recent pay raise that will impact future earnings. Paystubs should also be evaluated to determine if there are any discrepancies in the year-to-date amounts. If so, the missing information must be obtained. When using paystubs, the most recent should be used and they should be consecutively. If one or more checks are not reflective (high due to a one-time bonus, or low due to illness, for example) they should not be used in the calculation.

Documentation must be in the case file regarding the method of computation and why any paystubs are not used in the computation. When income is from a new source, the pay rate has increased (or decreased) or when the numbers or hours to be worked has increased or decreased, the income should be projected from the best information available. Weekly and biweekly income must be converted to a monthly amount.

Budgeting - Rules are dependent upon frequency and regularity of income. The case record is to be documented as the method of computation.

6111 **Regular Earned or Unearned Income and Deductions** - Once the full monthly amount is determined, that same amount of income shall be budgeted providing the individual anticipates continued regular income and deductions. A new budget is required prior to redetermination only if regular income becomes irregular, there is no longer any income (not applicable to a job change if earnings remain regular), or there is a change in the monthly amount of regular income.

6112 **Irregular Earned or Unearned Income and Deductions** - For income and expenses received or billed more frequently than on a monthly basis (i.e., weekly, biweekly, etc.), the amount to be budgeted shall be based on converting a "representative" amount to a standard amount of

anticipated monthly income or deductions. "Representative" is defined as a month in which the amount reflects a full month's benefits or wages, or deductions.

6112.01 - Income and deductions in the same weekly amount are to be multiplied by 4.3. If the income or deduction amount received is in differing weekly amounts, a representative amount shall be determined and then multiplied by 4.3.

6112.02 - Income and deductions in the same amount every 2 weeks are to be multiplied by 2.15. If the income or deduction amount received is in differing amounts every 2 weeks, a representative amount shall be determined and then multiplied by 2.15.

6112.03 - Income and deductions in the same amount twice per month are to be added together to obtain a monthly amount. If the income or deduction is in differing amounts twice per month, a representative amount shall be determined and then multiplied by 2.

NOTE: To prospectively estimate semi-monthly income from a new job, (when paychecks are not available to average) pay periods with varying hours must be taken into account. The easiest and most accurate way to make this determination is to calculate a weekly estimate, times 2.15 times 2. Multiplying the weekly amount time 2.15 will take into account pay periods that have fluctuating hours. For example, a person working 40 hours a week will have more than 80 hours in a pay period when paid semi-monthly. Taking 40 X the hourly rate X 2.15 X 2 will get a closer anticipation of projected income than taking 40 X the hourly rate X 2 X 2.

6113 Irregular and Intermittent Income - Received on a monthly basis in differing amounts or deductions bill monthly in differing amounts shall be averaged. (see ^6200^)

Actual income shall be used in computing prior medical eligibility (see ^6311.02^) and in computing any month in which the amount of income is not representative.

6113.01 - Once a standard monthly amount is established, it may continue to be budgeted through the redetermination period. However, a new budget is required:

(1) - for medical assistance when income terminates and there continues to be a spenddown in place;

(2) - for HealthWave when income decreases and results in elimination of a premium requirement.

For recomputing eligibility in medical assistance spenddown cases based on a change or termination in income, use the converted or actual income amounts established for the case prior to the month of change. In addition, if income continues, establish a new converted monthly amount based on anticipated income from the month of change through the end of the base period. In some instances, it may be appropriate to use an actual income amount or a separate anticipated income amount for the month of change particularly when there is a mixture of old and new income amounts in that month (e.g., client receives an increase in hourly wage which takes effect in the middle of the month).

06200 Income Averaging -

6210 Income Averaging - The income averaging budgeting method is used to budget self-employment and intermittent (earned and unearned income) in the Medical Assistance program. In addition, for Medical Assistance, earned and unearned income received in differing amounts on a monthly basis may be averaged.

6211 Intermittent Income - For intermittent income, the monthly amount shall be established by dividing the income by the proper number of months for the period that the income is intended (e.g., 3 months for quarterly, etc.). A fair estimate for the time period used for averaging shall be established with the client. The case record shall clearly indicate that the income is being treated as intermittent income.

Since intermittent income is counted from the date of receipt and budgeted for the period of time that it is intended, it is possible that two monthly amounts could be considered for the same month. (See ^5213^)

6212 Self-Employment Income - See ^5413^ for guidelines to determine if an individual is self-employed. For self-employment income, an average shall be established based on the guidelines below.

6212.01 Tax Return Filed - When a tax return has been filed, the average shall be based on the most recent year's income tax

return filed. Provided the return reflects a full year of self-employment earnings, a twelve month average shall be established.

6212.02 Tax Return Not Filed or Does Not Contain Full Year's Earnings - If a tax return has not been filed (e.g., employment just started or client has not filed a return) or does not reflect a full year of earnings, an initial average shall be established based on at least 3 calendar months of income which are reflective of the individual's income pattern. If the earnings reported on the tax return are representative, an average can be established based on that information dependent on the number of months reflected for the earnings reported. Otherwise, the calendar months used to establish an average must be consecutively prior to the month of application or the month in which the average is being calculated.

Income must be counted by the calendar month received. An average shall exclude only the first month of earnings when that amount is not representative. (See ^6111^.) A prospective estimate shall be used until an average can be instituted based on methodologies for using actual or anticipated income in ^6111^. When at least 3 calendar months of income are known following use of the prospective estimate and these months reflect the individual's income pattern, an average is to be established. However, if additional calendar months are necessary to more accurately reflect this pattern, the average should incorporate these months.

Once an average is established, it may continue through the review period. When income is reaveraged (e.g., review or redetermination), at least 3 of the most recent calendar months shall be used. Once again, additional months should be used if necessary to accurately reflect the person's income pattern. However, once a full year of earnings is obtained based on tax return information, a new average is to be established with this information at the time of the next scheduled review and remain in effect until the following year's tax return information is available except as indicated below.

For self-employment, the average is determined by totaling all adjusted gross earnings in the months being counted and dividing by the respective number of months. The calendar months being used and the corresponding earnings must be clearly documented in the case record.

6212.03 Need for New Estimate/Average Based on Changes in Income - Income shall not be calculated on the basis of prior income (i.e., income tax returns) when the individual has experienced a substantial increase or decrease in earnings. If the averaged amount does not accurately reflect the individual's actual circumstances because he or she has experienced a substantial increase or decrease in business, the self-employment income shall be calculated on anticipated earnings until a new average can be established. Self-employment earnings may also be reaveraged prior to the review period or the availability of tax return information if the current average is no longer reflective of the person's income. This can be done by either establishing a new average which incorporates the change in income pattern or an estimate until at least three calendar months of income which are reflective are known.

6212.04 Unearned Income - If unearned income is treated as self-employment and received on a basis other than monthly it is budgeted as intermittent income per ^5213^ so that income received prior to the first eligibility base shall not be considered. (See ^5413^).

6213 Income Producing Cost Deduction - Prior to the application of the income disregards and deductions listed in ^6212.02^, a standard income producing cost deduction of 25% of the gross earnings must be subtracted from the gross earnings of persons who are self-employed. Gross earnings includes the amount of any capital gains from business-related property but excludes the amount of cost of goods sold.

NOTE: The cost of goods sold are the amount of expenses incurred for products purchased if the business makes or buys goods to sell. Most commonly it is the cost of merchandise purchased to sell by the business or the cost of raw materials that are made into a finished product to sell. The amount of the deduction for the cost of goods sold can be determined from the current federal tax return (see ^6212.01^). Otherwise, the cost of goods sold is determined separately from other income producing costs. If the business maintains inventory logs, the cost of goods sold is determined by adding the total value of the business' beginning inventory and the amount of merchandise purchased to sell/manufacture. Reduce this amount by any merchandise used for personal use and the cost of the ending inventory. The result is the cost of goods sold. See item W-1 in the KEESM Appendix - The Cost of Goods Sold Worksheet. If the business does not keep inventories, the cost of goods sold shall be determined by the actual costs associated with merchandise sold in the period.

The adjusted gross income obtained from this shall then be used to determine countable income. However, if the individual disagrees with the 25% standard deduction, he or she has the option of using actual income producing costs as a deduction from gross self-employment earnings in place of the standard deduction.

NOTE: If use of actual income producing costs are requested and are less than the 25% standard deduction, the 25% standard shall be used. In addition, the 25% standard shall be used when no actual income producing costs are reported.

Income producing costs shall include only those expenses directly related to the actual production of income. It is the responsibility of the client to provide verification of income producing costs. In using the guidelines for income producing costs, it is not the intent of SRS to pay debts, set up an individual in business, subsidize a nonprofit activity, or to treat income on the basis of IRS policies. In determining the amount of income producing costs to arrive at the adjusted gross income, the following guidelines are provided and can be determined from the current federal tax return (form 1040) and applicable schedules and forms such as schedule C or F.

6213.01 - The cost of inventories and supplies that are reasonable and required for the business (such as items for sale or consumption and raw materials) are to be considered as income producing costs. Also included would be costs for seed, fertilizer, and plants.

NOTE: The amount of allowable inventories is determined as part of the cost of goods sold (see above). The cost of unsold inventory is not an allowable expense.

6213.02 - Wages and mandated costs related to wages for employees of the self-employed are to be considered as income producing costs. However, an exclusion cannot be allowed for wages paid to the self-employed person or other assistance plan members.

6213.03 - For non-home based operations, such items as business space and utilities can be considered as income producing costs. For home based operations, such items as shelter and utilities are not considered as income producing costs (as they are included in the basic and shelter standards) unless the items are clearly distinguishable from the home operation based on separate utility meters, separate rental costs, on the individual's income

tax forms.

6213.04 - Property taxes and insurance payments on equipment, vehicles, or property shall be allowed if evidence is provided that such payments are directly related to the business. This includes crop insurance. Privilege taxes such as licensing fees and general excise taxes that must be paid in order to earn self-employment income including severance taxes from income derived from mineral rights (e.g., oil royalties) are allowable.

6213.05 - For equipment, vehicles, or property purchased on an installment plan, the actual interest paid can be considered, but that portion of the payments with which the person obtains equity (the principal) cannot be deducted.

6213.06 - Business transportation costs, rental payments on income producing equipment, cost of repairs and maintenance of equipment, and storage and warehousing charges are allowable.

6213.07 - Depreciation on equipment, vehicles, or property is not to be considered as an income producing cost.

6213.08 - A loss from self-employment cannot be deducted from other income nor can a net loss of a business be considered as an income producing cost.

6213.09 - Federal, state, and local income taxes, monies set aside for retirement purposes, and other work-related personal expenses (such as transportation to and from work) are not allowable as these are contained in the work expense deduction.

When at least one person has wages and at least one person is self-employed, separate calculations are required and the countable incomes are then totaled.

06220 Deduction from Income -

6221 Deductions for MA CM and TransMed (at the 6 month income review) - The following deductions are used in MA/CM programs to determine countable income.

6222 Persons Included in the Assistance Plan - For persons with earnings

who are included in the assistance plan, the following amounts shall be disregarded from the total nonexempt gross earned income (or adjusted gross for self-employed persons). The disregards shall be applied to each person in the plan that has earnings. If more than one person has earnings, separate calculations are required.

6222.01 - Work related expenses of $90 for each employed person. The following items are included in the work related expense: all income taxes; lunches; tools; special uniforms; transportation to and from work or child care providers; parking; and other work related expenses.

6222.02 - 40% of the remainder of the person's monthly gross earnings after application of the $90 work expense.

This disregard shall not be applied for initially establishing or re-establishing eligibility for a person unless the person was eligible for and received MA/CM in Kansas in one of the four preceding months.

6222.03 - Expenses paid for the care of a child or other dependent which are necessary for the person to accept or continue employment, seek employment, or attend training or pursue education which is preparatory to employment to the extent that the person is not otherwise reimbursed for the care. (Note that the deduction will benefit persons with earnings only.) Such amounts must not exceed $200/month for each child under age two or $175/month per individual for all other children or dependents and are allowable only for children or dependents in the home and in the family group. In order to be deducted such amounts must be verified and documented in the case file.

Child care deductions shall be budgeted prospectively in accordance with the type of case and applicable income methodologies described in ^6111^.

The child/incapacitated person care deduction shall be applied after application of the $90 and 40% earned income disregards specified above.

6223 Persons Not Included in the Assistance Plan - If a legally responsible person or mandatory filing unit member (KEESM see 4113) in the household is excluded from the assistance plan, all of that person's nonexempt gross earned and unearned income shall be considered. No income disregards shall be allowed.

06230 Deductions for Family Medical Programs - Deductions for the MA Spenddown, Medicaid Poverty Level, and HealthWave Programs - For persons with wages, a standard deduction of $200 for each employed person shall be subtracted from the total monthly nonexempt gross earned income (or adjusted gross for self-employed persons). This deduction includes the following items: all income taxes; lunches; tools; special uniforms; child care expenses and transportation to and from work or child care providers; parking; and other work related expenses.

If more than one person has earnings, separate calculations are required to determine total countable income.

The 40% earned income disregard applicable to the TAF program is not applicable to the MA, Medicaid poverty level, or HealthWave programs. The standard disregard reflected above is applicable to the earnings of a legally responsible person even if the person is not included in the assistance plan.

There is no disregard applicable to unearned income. Such income shall be counted in full.

The eligibility period is the time period on which need is computed. See Section ^7330^ for policy and procedures for eligibility reviews.

06300 Eligibility Period -

6310 Eligibility Period - The eligibility period is the time period on which need is computed. See Section ^7330^ for policy and procedures for eligibility reviews.

6311 Eligibility Periods for Medical Programs - An eligibility or base period is the length of time used in determining financial eligibility for an individual or family. The length of the base period varies from one to six months depending on the medical program and any changes of circumstance as referenced in 6311.01. The date of receipt of a signed application in the local SRS office or the HealthWave Clearinghouse is the application date for determining eligibility.

For all medical programs other than HealthWave, the month of application establishes the first month of the current eligibility base period provided all eligibility factors, with the exception of a spenddown, have been met. On request of the client, a 3 month prior eligibility base period shall be established. (See ^6311.02^.) For cases determined eligible without a spenddown, the effective date of eligibility will correspond with the beginning of the eligibility base and will begin

with the first day of the first month of the medical base period. For spenddown cases, eligibility cannot be certified until the spenddown has been met. However, the effective date of eligibility may precede the date on which the spenddown is actually met.

Since suspension, closure, and denial are alternative administrative procedures that result in the withholding of benefits to the client when there is unmet spenddown, a base period can be established and maintained regardless of which procedure is chosen. Denied applications establish an eligibility base period and an application month when the reason for denial is excess income resulting in spenddown. (See ^1406.02^(3). Closures within an eligibility base period because of increased spenddown do not change the base period. A reapplication received outside of a previously established base shall be treated as a new application without regard to any previous base except for a determination of prior medical eligibility. (See ^6311.02^.) Once an eligibility base is established, it can be shortened or changed in accordance with ^6311.01^. Ineligible months are counted as part of the eligibility base period only when ineligibility occurs within an established base period.

For HealthWave, the month of application does not establish the first month of the current eligibility base period. The base period begins with the first month the eligible individual is enrolled in a managed care health plan per ^2470^. There is no eligibility for HealthWave for any months prior to that first enrollment month. Thus the effective date of eligibility and the eligibility base period will always correspond to the first day of the first enrollment month.

6311.01 **Current Eligibility Periods** - Automatic eligibility based on receipt of cash (TAF or SSI) continues as long as cash eligibility exists. (See ^2220^ and subsections). This includes qualifying persons who are eligible for a payment of less than $10. Eligibility for medical may continue once cash eligibility ceases for children and pregnant women based on the provisions of ^2300^, ^2310^, and ^2320^. Automatic eligibility for cases which are not the responsibility of EES continues as long as SRS has the responsibility for payment.

For the non-cash cases, the eligibility base will be 6 months except for MA CM cases and MP (both Medicaid and HealthWave) programs. A one-month eligibility base shall be used for these programs. The 6 month base will be shortened, however, in the following circumstances:

(1) - When a recipient becomes eligible for cash assistance

(TAF, GA, RE, or SSI) or for MA CM.

(2) - When a recipient begins receiving long term care in a Medicaid-approved institution.

(3) - When a recipient begins HCBS.

(4) - When a recipient is interprogram transferred from MA to MS or vice versa.

(5) - When the only person in an assistance plan dies and eligibility has not been determined due to a spenddown.

If the applicant dies or if an application is made on behalf of a deceased person, eligibility will begin no earlier than the third month prior to the month of application.

(6) - When the only recipient on an MA or MS case becomes eligible for Medicaid poverty level coverage, or coverage through foster care.

(7) - When two or more MA or MS recipient family groups combine into one assistance plan. In such instances, the previous bases shall be shortened and a new base period started with the combined family group.

6311.02 Prior Medical Eligibility (Not Applicable to HealthWave 21) - An applicant for medical assistance may request a determination of medical eligibility for a 3 month period prior to the month of application. The month of application establishes this prior medical period. A request for prior medical must be made in the month of application or the two following months. Requests made after this time shall be denied as they would be more than 3 months from the applicable prior period. See ^2341.02^ and ^2460.02^ regarding prior coverage determinations for children being added to an existing MP program.

Prior eligibility can be established even though there is no eligibility for the current base period. However, there is no eligibility in any prior month for an individual who does not qualify for Medicaid.

NOTE: Prior HealthWave 21 coverage is only available for certain HealthWave eligible newborns. (See ^2501^) Other HealthWave eligible children may be eligible for prior medical

coverage under the Medicaid program.

Except for persons requesting MA CM or in the Medicaid poverty level program, a 3 month eligibility base shall be used unless one of the following conditions exist:

(1) - Part or all of the prior base period falls into a previously established medical base period.

(2) - Part or all of the base period falls within any month in which the client was a cash recipient (TAF, GA, RE, or SSI) or a MA CM or Medicaid poverty level recipient.

(3) - The individual is not categorically eligible for any medical program in one or more months of the base period (i.e., is not a child, a pregnant woman, or a caretaker).

(4) - The individual was not part of the current family group in one or more months of the base period.

If, in the above instances, the assistance request includes other individuals in the family group, only the individual would be excluded for the applicable months. If the assistance request is only for the individual, the prior base period shall be shortened to exclude those months. However, if the client received cash assistance (other than SSI) in another state, those months shall be included in the prior period but the amount of assistance received would not be considered as income.

For the Medicaid poverty level or for MA CM, a one month base period shall be used in accordance with ^6311.01^ for each month of the prior period. Eligibility can be determined for any one or all of the 3 prior months. MA CM shall be used to provide prior medical benefits to caretaker relatives seeking benefits only and persons who do not meet caretaker status in the current month but did so in any of the prior months for which eligibility is requested.

Financial factors of eligibility apply to the entire base period. Eligibility factors other than the income shall affect eligibility for each of the months separately. Eligibility shall be effective only for the months in which the client meets both the financial and nonfinancial factors of eligibility.

06400 Medical Program Standards -

6410 Medical Program Standards - For the Medicaid poverty level, HealthWave and TransMed (at the six month income review) programs, standards have been established based on a percentage of the federal poverty level. If countable income does not exceed these standards, there is eligibility. For the MA (spenddown) program, standards have been established which are the amounts of monthly income protected from medical expenses to allow applicants/recipients to meet their maintenance needs. If countable income does not exceed these standards, there is eligibility. If countable income exceeds the standards, a person can "spenddown" the excess and become eligible.

6410.01 Standards in the Medicaid Poverty Level and HealthWave Programs - To be eligible, the total countable income must not exceed the monthly poverty level standards based on the appropriate number of individuals. See KEESM Appendix F-8 for the Medicaid and HealthWave standards.

6410.02 Standards in the MA Program - The protected income budgeted is the independent living standard for the number of persons in the plan and any legally responsible persons in the family group. In addition, in determining the eligibility of a pregnant woman for the MA program based on the provisions of ^2353^, the needs of the unborn child and the needs of the father of the unborn, if in the home, shall also be included in determining the protected income level. An SSI recipient shall not, however, be included in determining the protected income level. For 9 or more persons, see KEESM Appendix F-8, Protected Income Level Table.

06500 - Determination of Financial Eligibility

6510 Need - (1) - Need is a factor of eligibility in all categories of assistance and shall be determined through the application of standards by use of the budgetary method.

(2) - Need requirements and countable income shall be documented in the KAECSES System or on the appropriate budget form.

6511 Financial Eligibility in the Medicaid Poverty Level and HealthWave Program (see 6514 and subsections for Caretaker Medical [MA-CM], TransMed [MA-WT] and Extended Medical [MA-EM]) - Financial eligibility exists if countable income does not exceed the allowable poverty level standards and resources do not exceed program limits, where applicable. A person cannot spenddown to obtain

eligibility under any of these programs.

6512 Financial Eligibility in the MA Program - Spenddown (Not Applicable to MA CM) - Financial eligibility exists if allowable incurred medical expenses, as specified in this section, equal or exceed the spenddown for the base period and resources do not exceed program limits. See ^6410.02^ for establishing the spenddown amount.

6512.01 Allowable Expenses - Allowable expenses incurred outside of the current eligibility base are only allowable if the individual is still legally obligated to pay the expense and such expenses have not been previously applied to spenddown in any other base period in which the person became eligible. The amount of these expenses applied to spenddown within a particular base period shall be the amount due and owing as of the first day of that base period. This provision includes instances in which the individual has taken out a loan to pay the expense or charged the expense on a credit card. The unpaid portion of the loan or credit card balance attributable to the original medical expense shall be regarded as a due and owing expense which can be applied to spenddown.

The amount still due and owing shall be determined by subtracting all payments made on the loan or credit card balance prior to application of the expense in a base period from the original expense amount. The remainder shall be regarded as due and owing. Verification of the initial medical expense as well as payment made will be necessary.

All expenses which are incurred by persons in the assistance plan as well as those incurred by legally responsible family group members are allowable within the limitations described above. In addition, if a pregnant woman is included in the assistance plan in accordance with ^2353^, the expenses incurred by the father of the unborn child, if in the home, shall also be applicable. Such expenses do not actually have to be paid to be allowed against the spenddown. The client will choose which of his allowable expenses he wishes to apply on the spenddown. Failure by designated providers to collect from the client does not shift responsibility to the medical program. A medical payment can be made only for the excess expenses.

Payment for or assumption of medical expenses by a third party, whether legally liable or not, negates the client's responsibility to pay; therefore, such medical expenses cannot

be considered against the spenddown. This includes the portion of any medical expense paid by Medicare or another health insurance. The portion not covered by insurance, such as the co-payment or deductible, is allowable. See ^6512.02^ for exceptions of when expenses are allowable when paid by a third party.

The following expenses are allowable against a spenddown when the client provides eligibility staff with evidence that he has incurred such expenses within the limitations established above.

(1) - The pro rata portion of medical insurance premiums for the number of months covered in the eligibility base period regardless of the actual date of payment, past or future, are allowable.

Medicare premiums not covered by Buy-in are also allowable. See EES Policy Memo 99-10-04 for guidelines on applying such premiums when Buy-in is first initiated. Premiums which are subject to Buy-in are not allowable even if the client pays them (or they are withheld) prior to completion of the Buy-in process as such amounts are subject to repayment.

NOTE: Additional costs consumers pay for Medicare Replacement polices will not be reimbursed through the Buy-in process but are an allowable medical insurance premium.

Premiums for hospital indemnity policies which pay a flat per day amount are not deductible as they are viewed as income replacement policies rather than medical insurance. However, certain indemnity-type policies pay based on specific services received and charges incurred. In these instances, the premiums would be allowable. Each policy will need to be reviewed to determine whether the premium is allowable or not.

(2) - If medically necessary, all expenses for medical services incurred by the individual or a legally responsible family group member in the home are allowable. In addition, if a pregnant woman is included in the assistance plan in accordance with ^2353^, the expenses of the father of the unborn child, if in the home, shall also be allowable. See KEESM Appendix P-1 for Allowable Medical Expenses.

Medicaid co-payments are deductible. In addition, charges in a Medicaid approved institution can be allowed up to the private

rate for individuals subject to the gross income limit and whose income exceeds that limit. Otherwise the facility can only charge at the SRS rate if the individual's income is below the limit. Charges in a non-Medicaid approved institution are not allowable including charges incurred during a transfer penalty. (See KEESM 8111.)

6512.02 **Expenses Paid by a Third Party** - Medically necessary expenses paid for by a public program funded by the State (or political subdivision of the State, such as a county), other than Medicaid, can be applied to spenddown. Only the portion of the expenses funded by the public program is allowable unless the client will continue to be obligated for the remaining portion of the bill. Such an expense is allowable in the base period in which it was incurred. Examples include expenses paid by Vocational Rehabilitation, the Family Support Program, Kansas Health Insurance Program for the uninsurable, certain programs administered by the Department of Health and Environment, such as those through Children with Special Health Care Needs, the
Infant/Toddler Program and Other Title V programs and non-Title II AIDS Drug Assistance Program/Ryan White (KEESM 2694) payments. Also included are services paid by Donated Dental Services, Adult Emergency Support Services/APS Emergency Funds (KEESM 12650), the Community Support Medication Program and expenses subsidized on services received through a Community Mental Health Center or Community Developmental Disability Organization. For prescription drugs purchased with a Medicare Approved Drug Discount Card (KEESM 2911) the pre-discount cost of the item is allowed toward spenddown. The entire cost of the item is allowable even if the $600 credit was used to purchase the drug. Services provided for or paid through Hill-Burton funds, Ryan White funds or the Kansas Farmworker Health program is NOT allowable.

6513 **Meeting a Spenddown** - When allowable incurred medical expenses equal or exceed the spenddown eligibility exists. The spenddown for the entire eligibility base must be met before there is eligibility. Once met, eligibility exists for all months of the base period in which categorical, nonfinancial, general and other financial eligibility criteria are met.

The Case Manager must notify the fiscal agent of the expenses the client has chosen to apply to the spenddown so that such bills will not be paid through the medical program. Initial notification must be no later than at

the time eligibility is certified and any subsequent changes in this information must be communicated immediately.

Eligibility under a spenddown shall be authorized on KAECSES beginning with the month of the latest date of service used to meet the spenddown. Regular medical eligibility would be reflected for that month and subsequent months in the base period in which eligibility exists. Because months prior to the month of the last services date are not reauthorized, spenddown eligibility will continue to be reflected for those months. If the spenddown was met entirely with due and owing or non-Medicaid covered expenses, regular eligibility shall be authorized for each eligible month of the base period.

6514 Establishing Financial Eligibility in the Family Medical Programs (MA CM, TransMed, Four-Month Extended Medical -

6514.01 Caretaker Medical (MA-CM) - Financial eligibility exists if countable income does not exceed established limits for TAF cash assistance (see KEESM 7510).

6514.02 TransMed (MA-WT) - There are no financial eligibility criteria for establishing the first six months of TransMed coverage. The family must meet the criteria in ^2231.02^ in order to establish the initial six months of coverage.

6514.03 Extended Medical (MA-EM) - There are no financial eligibility criteria for establishing the four-month Extended Medical period. The family must meet the criteria in ^2241^ and subsections.

06520 Continuing Financial Eligibility -

6521 Continuing Financial Medical Eligibility - When circumstances change, adjustments will be made as necessary depending on the category of medical coverage. For persons eligible based on receipt of cash assistance or SSI, changes of circumstances may affect the basis of eligibility. For the Medicaid Poverty Level and HealthWave programs for children and pregnant women, changes in income will not impact eligibility based on continuous eligibility provisions. Changes in the amount of earned income do not impact eligibility for TransMed during the first six-month period. Income is reported by the end of the 5th month and examined to determine eligibility for the second six-month period in accordance with ^2231.04^. If the family meets the income guidelines for the second six months, an increase in income during the

second six months of coverage will not impact eligibility. All other changes must be evaluated to determine if eligibility criteria continue to be met.

6522 Continuing Financial Medical Eligibility - When circumstances change, adjustments will be made as necessary depending on the category of medical coverage. For persons eligible based on receipt of cash assistance or SSI, changes of circumstances may affect the basis of eligibility. For the Medicaid Poverty Level and HealthWave programs for children and pregnant women, changes in income will not impact eligibility based on continuous eligibility provisions. Changes in the amount of earned income do not impact eligibility for TransMed. All other changes must be evaluated to determine if eligibility criteria continue to be met.

07000: **Reporting Changes** -

07100 Reporting Changes -

7110 - Households receiving medical assistance are required to report changes. The specific reporting requirement is determined by the program and the circumstances of the household. The requirements for reporting changes are listed in this section. No additional reporting requirements shall be placed on either reporting group.

7111 Households Exempt from Monthly Reporting - All medical only households are EXEMPT from monthly reporting requirements. These households are required to report certain changes in circumstances within 10 calendar days from the date the change is known. See ^7211.01^.

07120 Household Responsibility Prior to Approval - New Applications and Applications Filed after a Break of One Month or More in Assistance - Clients must report all changes of circumstances prior to case approval.

The client must report within 10 calendar days from the date the change is known. The Case Manager is responsible for requesting or otherwise obtaining other information or verifications necessary to determine the household's eligibility for any month.

07200 Non-Monthly Reporting Households -

7210 - All households listed in ^7111^ shall be referred to as non-monthly

reporting households. Reporting responsibilities and agency actions for non-monthly reporting households are discussed in this section.

7211 Responsibility after Approval for Non-Monthly Reporting Households - Those households exempt from monthly reporting are required to report the following changes in circumstances within 10 days of the date the change becomes known to the household.

7211.01 - Change Reporting Requirements for all medical Non-Monthly Reporting Households -

(1) - Changes in the source of income (earned and unearned) For Poverty Level MCD SSI income is the only required income to be reported.

(2) - When the amount of earned income being counted increases or decreases by more than $100.00 per month. This requirement is for Family Medical Programs only.

(3) - When the amount of unearned income being counted increases or decreases by more than $25.00 per month This requirement is for Family Medical Programs only.

(4) - Changes in household composition, including marriage, separation, or divorce. This requirement is for all medical programs.

(5) - Changes in residence, including moving into or from an institution or hospital. This requirement is for all medical programs.

(6) - Entitlement to or termination of Medicare coverage, change in any third party insurance plan. This requirement is for all medical programs except HealthWave 21.

Households may report a change in their circumstances by telephone or in writing. Other changes in circumstances are not required to be reported until review, including changes in medical expenses for food stamps.

7212 Processing Changes Reported by Non-monthly Reporting Households - Processing a Change - When the agency receives information that a change has occurred, the Case Manager shall act on the changes within 10 days after the date the change is reported by taking the following actions:

(1) - Document in the case file the reported change, the date the change occurred, and the date the change was reported;

(2) - Determine if verification or additional information is required (see ^1325.01^);

(3) - Contact the household to request needed information or verification as soon as possible;

(4) - Determine eligibility issuance month according to the provisions of ^6100^.

(a) Households reporting changes which would result in a change in benefits must provide any required verification within 10 days of the date of agency request. No change in benefits shall be granted if the household does not provide the required verification. If no verification is required or if the verification required is received within 10 days from the date of verification request, the change in benefits are to be granted effective the month following the month the change is reported. If the verification is received after 10 days from the date the verification was requested, the change benefits would be effective the first month following the month the verification is received.

(b) Changes resulting in ineligibility or a decrease in benefits shall effect eligibility the first month possible considering timely notice requirements

7213 **Notices to Households NOT Subject to Monthly Reporting** - The agency shall provide the household with adequate notice, as defined in ^1422.01^, of any changes from its benefit. Additionally, the notice of action must meet the definition of timely and adequate notice, as defined in ^1422^, if the household's benefits are being terminated. Refer to ^1420^ for exceptions to these notice of action requirements.

07220 **Failure to Report** - If the agency discovers that the household has failed to report a change, as required in ^7200^ and, as a result, received benefits to which it was not entitled, a claim shall be filed against the household. If the discovery is made within the review period, the household is entitled to a timely and adequate notice of adverse action if the household's benefits are reduced.

A household shall not be held liable for a claim because of a change in household circumstances which it is not required to report in accordance with ^7200^. Individuals shall not be disqualified for failing to report a change

unless disqualified in accordance with fraud disqualification procedures.

07230 Whereabouts of Recipient Unknown - Except for person continuously eligible for medical coverage, in instances when the agency does not know the whereabouts of a recipient, the agency shall send an Informational Notice to the last known address which will advise the recipient to inform the agency as to his whereabouts by a given date or his case will be closed. If there is no contact by the required date, the case is to be closed and a final Notice of Action is to be sent to the last known address. (See ^1423.06^.)

Coverage shall not be terminated for persons eligible under the continuous eligibility provision of 2300, 2310, and 2320. If the agency becomes aware that residency requirements of 2050 are no longer met coverage shall be terminated.

07300 Transfer of Assistance - When a recipient requests a case be managed by another service center due to a move or other reason, the worker and the client or responsible party shall determine where the case should be managed based on the best interests of the client. If the recipient chooses to have benefits and services established and maintained in the service center for the new county, the current office is responsible for transferring the case to the new office. All existing paper files and electronic cases should be transferred to the new office at the time of the case transfer.

If the recipient now resides in another county, but chooses to continue to have the case managed by the current office, Clearinghouse/EES staff in the current office should process the change in accordance with ^7212^. KAECSES should be updated with the known changes.

7301 Pending Applications - When an applicant requests the case be managed by another service center due to a move or other reason prior to application processing, the worker and the client or responsible party shall determine where the case should be managed based on the best interests of the client. If the applicant chooses to have benefits and services established and maintained in the service center for the new county or a service center different from the current one, the current office shall immediately forward both the electronic file and the paper file to the new office processing any expedited benefits prior to transfer. An informational notice shall be sent to the client to advise of the action and of the new office responsible for the application.

7302 Open Cases - If a case is in open status both the old county and the new county has responsibilities in completing the transfer. Supervisory review is required prior to transferring an open case to the new county. The original review period remains for all programs.

7302.01 **Sending County's Responsibilities** - Prior to sending a case to the client's new county of residence, the current county must complete the actions listed, including those for specific program involvements.

7302.02 **Case Instructions** - Once the sending county has been notified of the change of address it shall complete the following steps:

(1) - Correct address information on KAECSES. When a client moves without providing a new address, use procedures in ^7230^.

(2) - Update KAECSES with known changes including notifying CSE of the change in address or any other change in absent parent.

(3) - Send a notice advising the client the case has been transferred. If a review, application, or monthly report form is needed, the sending county is also responsible for mailing these documents. NOTE: When a recipient reports a move to the new county, the new county shall inform the old county of the move in order for the old county to initiate the transfer process as specified above.

(4) - For all medical programs, authorize the last paid benefit month (after updating ADDR) to ensure proper managed care assignment in the new county.

(5) - Set a worker alert for the new county to review the current record. The alert shall have a due date of the 5th of the month following the month the transfer is reported. The alert message shall read "ICT Complete."

(6) - Enter the new caseload number on KAECSES and transfer both the electronic and paper file to the new county using the appropriate procedures as outlined in the KAECSES User Manual, Volume II, Special Procedure 611.

7302.03 **Program Instructions** - The sending county is also responsible for completing the following actions for the following open programs and documenting any other information known that may impact eligibility:

For MA CM programs no action to adjust eligibility based on

the shelter standard for the new county or changes in household arrangements shall be taken by the sending county.

07320 Receiving County Responsibility -

7321 Receiving County's Responsibilities - Receiving County's Responsibilities - Once the worker alert is received by the new county announcing the move, the new county assumes the following responsibilities. Any resulting adjustments in eligibility because of changes occurring as a result of the move are to be made no later than two months following the month of transfer following the reporting rules of ^7212^ as appropriate. Any required reviews or applications are also the responsibility of the receiving county to process.

7322 Closed Cases - If the case is in closed status in the old county, the old county is responsible to transfer the case to the new county. On KAECSES, a closed case may be transferred to the new county following normal procedures.

The application may be used to transfer a closed case to a new county when the client reapplies prior to the effective date of closure but subsequent to be closure notice being issued and when reapplication occurs within the month following the month of closure. If the client reapplies after the month following the month of closure, an application shall be required.

07330 Reviews -

7331 - All categories of assistance require periodic review. At the expiration of the review period, entitlement of benefits ends. Further eligibility must be determined through the review process based on a new application and verification as required.

7332 Review Process - The review process is a complete re-examination by the agency concerning all factors of eligibility. In the process, the appropriate review form shall be used along with the rest of the agency record. The purpose of the review is to give the client an opportunity to bring to the attention of the agency his or her needs and to give the agency an opportunity to re-examine all factors of eligibility in order to determine the client's continuing eligibility for assistance.

7333 Notice of Expiration - A notice of expiration of the review period shall be sent to each household. The local agency shall provide an application

form with the notice of expiration. When a review must be made and it is known that the recipient is temporarily visiting away from his or her residence, the notice of expiration and appropriate form should be mailed to the temporary address.

In all programs, a notice of expiration shall be mailed to the household no later than the first day of the last month of the current review period.

NOTE: This provides timely notice of the ending of benefits; therefore, further timely notice is not required to affect benefits for the start of the new review period.

07400 Client Requirements for Timeliness -

7410 Application - For all programs, the application for review must be received by the 15th day of the last month of the review period.

7411 Information/Verification - All information and/or verification shall be provided by the requested date. Clients must submit any required verification or additional information within 10 days from the date of the initial request in order to ensure the rights to uninterrupted benefits, provided the deadline to submit such verification does not occur prior to the date the application was timely filed.

Follow the verification requirements at initial application, except that non-citizen status, providing an SSN, residency, and identity, do not have to be reverified unless a change has been reported or it is questionable.

07420 Agency Action of Reviews - Agency Action of Timely Reapplication - If reapplication for benefits is filed timely and all review requirements are met, the agency shall act upon the information to ensure uninterrupted benefits. Workers shall take action on timely filed reapplication within the following time standards.

For all households that have timely filed an application for review and met all required review procedures, the Case Manager shall approve or deny the application and notify the household of its determination by the end of the current review period. Reviews processed by the last work day in the last month of the review period are considered timely.

07430 Failure to Act -

7431 Household Failure to Act - A household which submits a timely

application for review but submits all verification in an untimely manner shall lose the right to uninterrupted benefits. If eligible, these households shall be provided benefits within 30 calendar days after the application was filed.

A household which fails to submit required verification, shall lose its right to uninterrupted benefits and shall be denied by the end of the current review period.

Any application for review not submitted in a timely manner shall be treated as an initial application. The timeliness provisions of ^1405^ apply.

7432 **Agency Failure to Act** - Agency failure to provide normal issuance of benefits to an eligible household, which submitted a timely application for review, in accordance with the above provisions shall be considered an administrative error. These households shall be entitled to restoration of benefits if, as a result of such error, they were unable to receive benefits for the month following the expiration of the review period.

07440 Frequency of Reviews -

7441 **Frequency of Reviews** - For all programs, cases are to be reviewed via the application form. The length of the review periods are noted below; however, all programs allow a review period for less than 12 months to be established when needed to match the review period on an existing program.

7442 **All other medical-only cases shall be reviewed once every 12 months (see 7442.03 for TransMed provisions). -**

7442.01 - For the Medicaid poverty level and HealthWave programs for children, the review period should usually correspond to the 12 months in which there are both Medicaid and HealthWave eligible children, the Medicaid review period can be extended beyond 12 months when the case is initially established to link the Medicaid and HealthWave periods together.

A review may be completed when an application or review for other program benefits is received (see ^2313^ and ^2453^) or when a request for continuing coverage is made for a child moving into a new household without an open MP, MA CM or TAF program (see ^2341.02^ and ^2460.02^). Reviews are not required in these situations, but may be completed if it is in the

best interest of the family to do so.

7442.02 - For SSI cases, reviews need only be done when information is received on EATSS that the individual's benefits have been suspended or terminated, except as noted in KEESM 2639.

7442.03 For TransMed programs, the review period shall be set at a six - For TransMed programs, the review period shall be set at a six-month interval. The first six month review is not an official review, but a review of the family's income only. As such, the TransMed Income Report form will be used for the six-month income review instead of an application/review form. If the family qualifies for continuing TransMed coverage at the six-month income review, another six-month review period will be set. At the end of the 12 months of TransMed coverage, eligibility for other family medical programs for all family members covered by TransMed will be examined and approved if appropriate. A new 12 month review period and continuous eligibility period shall be set for those individuals who qualify for coverage under another family medical program (continuous eligibility does not apply to the MA spenddown program). If the family does not qualify for the second six months of TransMed eligibility at the six-month income review, the children on the case and any pregnant women, if applicable, will continue to be covered through the appropriate continuous eligibility period (See sections ^2300^ and ^2310^ and sub-sections). Any non-pregnant adults on the case will lose coverage at the end of the sixth month of TransMed.

08000: **Incorrect Payments** - Prevention of incorrect benefits is the responsibility of every SRS staff member, contracted staff member, and client. Incorrect benefits include both underpayments and overpayments for clients.

08100 Underpayments -

8110 Underpayments - An underpayment is the amount of assistance that a client did not receive but was entitled to.

Staff shall, at a minimum, document how the underpayment was calculated and the reason benefits must be restored.

8111 Situations Requiring Restoration of Benefits - Underpayments shall be corrected promptly using the program policies in effect for the month(s) in which the underpayment of benefits was made.

The following are the various situations in which a household may be entitled to restoration of benefits:

8111.01 - Benefits are lost due to Agency error;

8111.02 - Agency failed to give the household sufficient time to verify a deduction and, as a result, its benefits were lowered (see KEESM 1322.3(3));

8111.03 - Agency fails to take action within time frames on reported changes that increase the household's benefits (see ^7212^);

8111.04 - Fair hearing decision in favor of the household;

8111.05 - Administrative Disqualification Hearing decision reversed by court (see ^8520^);

8111.06 - Lost benefits ordered as a result of a class action or other suits (Example: USDA court orders)

8112 Medical Assistance Underpayments - Medical assistance underpayments are to be promptly corrected subject to the limitation that the provider must bill the agency for the expenses within the mandatory 12 month limitation period. In instances where eligibility was incorrectly denied, and it is documented that the provider will not return payment to the client, the client shall be reimbursed for the verified amounts paid to the provider, up to the proper rate for the service. There is no other provision for correcting of medical underpayments.

8113 Situations Not Requiring Restoration of Benefits - The following situations are handled as reported changes and the household is not entitled to restoration of benefits:

8113.01 - Verification of eligible alien status provided and member added (see ^2047.03^);

8113.02 - The household failed to report a change which would have resulted in an increase in benefits had the change been timely reported. Refer to ^7212^.

8113.03 - The household failed to timely provide necessary information. See ^7212^.

08200 Time Frames and Limits -

8210 Time Frames and Limits - Once it has been determined that an underpayment is due a household, these benefits shall be calculated and issued (unless offsetting of the full amount will occur) to the household as soon as possible but no later than 20 calendar days after the Case Manager becomes aware that an underpayment is due.

8211 Erroneous Denial - If an eligible household's application was erroneously denied, the month the loss initially occurred shall be the month of application or, for an eligible household filing a timely review, the month following the expiration of its review period.

8212 Erroneous Termination - If a household's benefits were erroneously terminated, the month the loss initially occurred shall be the first month benefits were not received as a result of the erroneous termination action.

08300 Overpayments and Claims - An overpayment is assistance that is over the amount to which the client is entitled. If a cash assistance overpayment results in ineligibility, a determination of medical eligibility shall be made beginning with the month of ineligibility for cash. Any resulting medical overpayment shall be calculated.

One or several months of overpayment become a claim when the cause of the overpayment(s) are due to the same or related causes. See ^8310^. A claim shall be established against any household that has received more assistance than it is entitled to receive.

08310 Establishing Types of Claims -

8311 Criteria For Establishing Types of Claims - Claims are classified according to the error cause as follows:

8312 Agency Error - Instances of agency error which may result in a claim include, but are not limited to, the following:

8312.01 - Prompt action was not taken on a change reported by the household;

8312.02 - The household's income or deductions were incorrectly computed or the household was otherwise assigned an incorrect allotment;

8312.03 - Benefits continued to be provided to a household after its review period had expired without benefit of a reapplication determination; or

8312.04 - Misapplication of policy.

8313 Client Error - Instances of client error which may result in a claim include, but are not limited to, the following:

8313.01 - Nonwillful withholding of information from a one-time failure on the part of a client to report a change timely (see ^7111^), which affects eligibility and/or the amount of assistance when:

(1) - The Case Manager has reason to believe that the client did not understand his responsibility; and

(2) - There was no oral or written misstatement by the client, or

8313.02 - Willful withholding of information such as:

(1) - Misstatement (oral or written) made by the client in response to oral or written questions from the agency;

(2) - Failure by the client to report a change timely (see ^7211^), which affects eligibility and/or amount of assistance;

(3) - Failure by the client to report the receipt of a payment which he knows, or should know, represents an incorrect benefit;

8314 Fraud Error - A fraud error is a willful client error which has been found to be fraud in accordance with the provisions in ^8400^. An individual shall be considered to have committed fraud:

(1) - For medical assistance, when the individual has been legally determined to have committed fraud through a court of appropriate jurisdiction.

Fraud error status is not established if a court's resolution to a willful error situation is to place the person on diversion unless the person has signed a disqualification consent agreement.

08320 Instances not Requiring a Claim -

8321 Instances Not Requiring a Client or Agency Claim - A claim shall not be established if an overpayment occurred as a result of the agency failing to insure that the household fulfilled the following procedural requirements:

8321.01 - Signed the application;

Other instances when a claim should not be established include:

8321.02 - Assistance granted in accordance with the treatment of income policies or the inability to act on available information due solely to issuance cutoff dates and/or timely notice requirements do not constitute an incorrect payment.

8321.03 - Eligibility errors related to citizenship or alien status will not cause incorrect payments in the following situations:

(1) - eligibility was based on verification of satisfactory immigration status by the Immigration and Naturalization Service (USCIS);

(2) - eligibility was approved to meet timely processing guidelines, but no USCIS response to a request for verification of immigration status has been received; or

(3) - eligibility was approved to meet timely processing guidelines, but the reasonable opportunity period allowed for alien applicants to provide documentation of their alien status had not expired. "Reasonable opportunity" shall be defined as 10 calendar days from the date of request.

8321.04 - Overpayments that occur as a result of the household not reporting a change in household circumstances that they were not required to report. See ^7211^.

08330 Time Frames and Limits for Establishing Claims -

8331 - For agency and client overpayments, the agency is required to prepare the claim and initiate recovery or attempt to initiate recovery by the end of the calendar quarter following the calendar quarter in which the overpayment is first identified.

8332 - For fraud overpayments, the agency is required to prepare the claim and initiate a referral to either the Fraud Unit or the Administrative Disqualification Hearing Officer by the end of the calendar quarter following the calendar quarter in which the overpayment is first identified.

08340 Computing the Overpayment -

8341 Computing the Overpayment - In calculating the amount of an incorrect benefit, the agency shall determine the point at which the correct information should have been reported and acted upon timely allowing for timely notice as appropriate. From that point the correct benefit for subsequent months shall be determined comparing the amount with the actual benefit issued.

For households who fail to report a change, the first month of overpayment shall be determined by allowing for the 10-day period to timely report changes and the 10-day period for Notice of Adverse Action.

EXAMPLE: If a notice of adverse action was required but was not sent, it should be assumed that the 10-day advance notice period would have expired without the household requesting a fair hearing. If a change was not reported, the claim shall be based on the first issuance that would have been affected had the household reported the change.

The Case Manager shall calculate the amount of overpayment using all nonexempt income the household actually received in the income month for the month of overpayment and considering expenses and deductions that were reported or were required to be reported, and should have been allowed at the time the original benefit for the month was determined. For persons with prospectively budgeted or averaged income the overpayment shall be determined using actual income received in the calendar month of the benefit. This includes using actual amounts for situations in which a conversion method (i.e., 4.3 times weekly amount) would have been used in nonmonthly reporting situations.

The following special provisions apply when computing an overpayment:

8341.01 Medical Assistance Provisions - For medical program purposes, when a recipient fails to meet an increased spenddown resulting from an increased income or other changes of circumstances within an eligibility base period, medical payments previously made within the base period shall not be considered overpayments unless it is determined that the client willfully withheld information. In the case of willful withholding of information, overpayments shall be computed from the date the case should have been adjusted had the information been timely reported. The amount of the overpayment shall be computed based on payment information from HCPMP. For alleged fraud situations referred to the Fraud Unit, that unit is responsible for obtaining the necessary information and forwarding it to the Case Manager.

For other overpayment situations, information on claims can be obtained through the MMIS system. See the SRS MMIS User Reference for Field Staff Manual.

08350 Establishing Claims and Repayment Agreements -

8351 Establishing Claims and Repayment Agreements - Once the Case Manager has determined the amount of overpayment, a claim shall be entered on the OVCA screen in KAECSES. The claim shall be designated as either a client, agency, or fraud claim. Suspected fraud claims shall be initially established as client claims. If a determination of fraud is made, the claim type shall then be changed from client to fraud.

Collection action for client or agency claims with no restored benefits due shall be initiated by sending the household a repayment agreement.

NOTE: Collection action should not be initiated on suspected fraud claims (either referred for prosecution or for an administrative disqualification hearing) until after the determination of fraud has been made. Refer to ^8500^ for initiating collection action on fraud claims.

After a claim determination has been made, the local office shall send a repayment agreement and proceed as follows:

8351.01 - Give the household 10 days to respond to the repayment agreement. The reason the claim occurred must be explained on the letter.

8351.02 - If the household responds with a payment on the claim, have the payment submitted according to established procedures.

8351.03 - If the household does not respond, or responds with a statement that it is unable to pay, promises to pay, or asks for a fair hearing, proceed as follows:

(1) - If the household responds by saying it cannot repay, the Case Manager shall consider any information known to the agency, in addition to the household's statement, documenting this information in the case file.

(2) - If there is ineligibility for continued assistance and the case is closed, the agency is still required to attempt recovery. At a minimum, the agency is required to initiate action to locate the former recipient and, if located, initiate some form of action to recover the overpayment. Such activities must be documented in the case record. To meet these requirements the agency must send a letter to the client at the last known address that advises the client to contact the Case Manager to work out a repayment plan. If the letter is returned, the case record shall be documented as to why it was not delivered. No further action is required when the person cannot be located. However, should the client reapply or the agency later learns the whereabouts of the client, recovery efforts must be reinstituted.

(3) - All repayment plans shall allow for complete repayment within 12 consecutive months, when possible. If total repayment is not possible within 12 months because of limited available resources, the plan will provide for complete recovery as soon as possible.

08360 Collecting Claims -

8361 Collecting Claims - The following special procedures apply when initiating collection action on claims.

8362 Methods of Collecting Payments - Claims shall be collected in one of the following ways:

8362.01 Lump Sum - (1) - Payments shall be collected from households in one lump sum cash payment if the household is financially able. However, the household shall not be required to liquidate all of its resources to make this one lump sum payment.

(2) - If the household is financially unable to pay the entire

amount of the claim at one time and prefers to make a lump sum cash payment as partial payment of the claim, it shall be accepted.

8362.02 **Installments** - If the household is not currently participating in the program with the overpayment and has insufficient liquid resources or is otherwise financially unable to pay the claim in one lump sum, a payment schedule shall be negotiated. Once negotiated, the amount to be repaid each month through installment payments shall remain unchanged. Both the household and the agency shall have the option to initiate renegotiation of the payment schedule if they believe that the household's economic circumstances have changed enough to warrant such an action.

If the household requests renegotiation, but the Case Manager feels that the household's economic circumstances have not changed enough to warrant the requested settlement (such as the fact that the household's source of income has not changed) then the Case Manager may continue renegotiation until a settlement can be reached.

8362.03 **Provisions Specific to Medical** - For medical cases not subject to the fraud provisions of ^8400^ or to other legal recovery efforts, an overpayment may be recovered only if there are nonexempt resources that are currently available. This includes any resources counted toward the allowable resource level of ^4010^.

If the overpayment is a result of an understated spenddown, the total amount of the overpayment cannot exceed the understated amount. If the overpayment is a result of excess resources, the total amount of the overpayment shall be the amount of claims paid (or subject to be paid) for the ineligible period not to exceed the amount by which the total nonexempt resources exceed the allowable resource level. (See ^4010^.) If the value of the total nonexempt resources vary during the ineligible period, the highest value obtained for that period shall be used. If ineligibility exists for a reason other than excess resources, the total amount of the overpayment shall be equal to the amount of claims paid (or subject to be paid) for the ineligible period.

When the amount of the overpayment has been determined and there are resources to recover from, the client may voluntarily

choose to make a repayment to the agency. If the client does not choose to make a lump sum repayment, a special spenddown shall be created in an amount equal to the amount to be recovered and shall be considered in the current eligibility base period.

Medical expenses may be counted against the special spenddown requirements if the expense is:

(1) - verified,

(2) - for a medically necessary (see Medical Services Manual) service, and

(3) - reported to the agency on at least a 6 month basis.

Medical expenses shall first be counted against regular spenddown requirements and then the special spenddown requirements.

The special spenddown mechanism may be used to recover medical program overpayments for both automatic and determined eligibles. There is no necessity that a client have a regular spenddown. However, special spenddown shall not be used in the Medicaid poverty level or HealthWave programs. If a special spenddown mechanism is used on regular spenddown cases, it is necessary for the client to report all medical expenses incurred until both spenddowns have been met. They may extend over more than one base period. If the client fails to provide the agency with this information and he reapplies at a later date, the special spenddown shall be considered to be unmet.

8363 **Special Criteria for Initiating Collection Action on Fraud Claims** - If a household member is found to have committed fraud (by any of the means described in ^8400^), collection action shall be initiated against the individual's household. In addition, a personal contact shall be made with the household, if possible. Such collection action shall be initiated unless the household has already repaid the overissuance. See ^8500^.

8364 **Claims Discharged through Bankruptcy** - Central Office shall act on behalf of FNS in any bankruptcy proceedings against bankrupt households owing food stamp claims. Therefore, if the local agency has knowledge of bankrupt proceedings against any household owing a claim, Central Office shall be notified immediately and the local agency

shall cease collection activity pending the outcome of the court proceedings. Collection action should be resumed (or initiated) after and in conformance with the final court action.

NOTE: To cease collection activity pending the outcome of bankruptcy proceedings. Cash claims cannot be terminated, so to cease collection, the repayment plan code must be removed. Claims must not be deleted. Once final court action is known, the discharged amount shall be compromised. This is done by notifying Central Cashier to enter the discharged amount with the Compromise method of recovery (CO).

08370 Transferring Claims -

8371 Transferring Claims - In certain situations, an active claim may exist on a closed case and the client that was responsible for the claim is receiving cash or food stamp benefits on another case. If the recovery method is to be by benefit reduction or offsetting, the claim must be transferred from the closed case to the active case. (Only cash benefits can be recovered from a cash case and food stamps from a food stamp case.) If recovery is by any other method, the claim need not be transferred.

8371.01 - To transfer a claim (with or without payments already credited), the following procedures are to be followed:

(1) - NO Payments Have Been Made on the claim:

(a) On the closed case with the active claim, screen print OVCA to determine and document the amount of the claim. THIS IS VERY IMPORTANT, because once the claim is deleted, the amount of the claims will NOT be accessible.

(b) Once the amount of the claim is documented by the screen print of OVCA, use the delete (DL) function and delete the claim from the closed case. This will automatically close the claim and set the balance to zero.

(2) - Payments Have Been Made on the claim:

(a) On the closed case with the active claim, screen print OVCA to determine and document the balance remaining on the claim. THIS IS VERY IMPORTANT, because once the claim is modified, the balance remaining will not be accessible.

(b) Once the amount of the remaining balance is documented

by the screen print of OVCA, use the change action function and modify the claim (each month, as needed) such that the remaining balance is equal to the amount of payments that have been made on the claim. Once processed, this will set the claim balance to zero.

Example: A claim was established in 1998 for $135.00, for the months of January 1998 through May 1998. The breakdown for each month is as follows: January - $25, February - $30, March - $30, April - $20, May - $30. Benefit reduction in 1999 collected $50 and the balance of the claim is now $85. The claim amount must be reduced to $50 in order for the claim to show a balance of zero. To do this, the change (C) function must be used to modify the claim for January to 0, February to 0, and March to 0. April will be left at $20 and May at $30 equaling $50. Since $50 was paid on the claim, it will zero out the claim balance once this change is processed. The remaining balance of $85 will be established on the new case. Any problems with this procedure should be referred to Help Desk.

8371.02 - Document why the claim is being transferred, and the name and case number of the case it is being transferred to.

8371.03 - On the case where the individual responsible for the claim is active, establish a claim with the remaining balance, documenting where the claim was transferred from, the original date the claim was established, and any other pertinent information.

8371.04 - Start benefit reduction, or complete offsetting as appropriate. Notify the PI of the recoupment (or offsetting) and explain why the reduction is occurring.

08380 Compromising Claims -

8381 Compromising Claims - The compromise method of payment shall be used in the following situations:

8381.01 - When a claim has been discharged in a bankruptcy. The amount discharged shall be entered as the amount compromised.

8381.02 - When the amount of the claim is reduced in accordance with a

court or Fraud Unit agreement. The amount determined uncollectible shall be entered as the amount comprised.

All actions to compromise the balance of a claim are done by Central Cashier following established practices for submitting payments. The compromise method can be used on all programs, and must be pre-authorized by Fraud Unit staff and/or the Central Office TOP Unit.

08400 Determination of Fraud - Any individual who is suspected of committing fraud for the purpose of improperly establishing or maintaining eligibility for medical assistance benefits shall be referred to the Fraud Unit or Administrative Disqualification Hearings Officer as appropriate for a determination of fraud.

An individual may be found guilty of fraud by any one of the following methods:

For medical assistance, when the individual has been legally determined to have committed fraud through a court of appropriate jurisdiction.

A referral may be made to the Administrative Disqualification Hearing Officer (ADHO) or to the local Fraud Unit regardless of the current eligibility of the individual.

08410 Definition of Fraud - Fraud is defined as having intentionally made a false or misleading statement, misrepresentation, concealment, or withholding of facts for the purpose of improperly establishing or maintaining eligibility.

08420 Medical Assistance Penalties - An individual who has been convicted of medical assistance fraud under 42 U.S.C. Sec. 1320a-7b shall be ineligible for medical assistance for one year from the date of conviction. Convictions under state law do not carry a disqualification period.

If a court fails to impose a disqualification period for any fraud violation, the state agency shall impose the appropriate disqualification penalty specified above unless it is contrary to the court order.

Only the individual, and not the entire household, found to have committed fraud, or who signed the waiver to an administrative hearing or a disqualification consent agreement in cases referred for prosecution, shall be disqualified.

Persons rendered ineligible under the above provisions shall be treated as sanctioned individuals for mandatory filing unit purposes in accordance with

KEESM 4113(2) for the cash program. Ineligible cash individuals may receive medical under a determined category if requirements are met. Pregnant women who are sanctioned remain eligible for medical coverage when continuous eligibility provisions apply. See ^2300^, and ^2222^.

08430 Determining the Proper Type of Referral - Before a referral for prosecution for suspected fraud can be made, it is necessary for the agency to first determine the amount of alleged fraudulent overpayment by following the procedures outlined in ^8340^. The same act of alleged fraud repeated over a period of time shall not be separated so that separate penalties can be imposed. Once this has been accomplished, the amount of the total alleged overpayment determines the type of referral which shall be made. If it is decided that a case will not be referred for prosecution, or the local Fraud Unit has declined prosecution and not recommended a referral to the Administrative Disqualification Hearing Officer, then the overpayment shall be handled as a client overpayment as outlined in ^8313^. The burden of proving fraud is on the agency. All referrals shall be reviewed by the Case Manager Supervisor prior to the referral being sent to either the local Fraud Unit or the Office of Administrative Hearings.

There is a $101 minimum amount of alleged fraudulent overpayment required to initiate a fraud determination action. Claims of $100 or less shall not be considered or pursued as fraud but instead should be treated as client errors and collected in accordance with provisions in ^8313^ and ^8350^. However, for attempted (alleged) fraud situations in which no benefits were provided, the $101 minimum does not apply and a fraud determination must be pursued.

Cases suspected of provider fraud are to be referred by memo to the Fraud Unit. This memo is to include all pertinent information currently available concerning the alleged fraud.

08440 Fraud Unit Referrals - A case shall be referred to the Fraud Unit when the total amount of alleged fraudulent overpayment is in excess of $1,000.

A threshold amount exceeding $1,000 may be utilized for this purpose if approved by the Office of Administrative Hearings and the EES Program Administrator after consultation with the local Fraud Investigator. The local Fraud Unit will make a decision as to whether or not to pursue prosecution through either civil or criminal action. Once a case is referred to the Fraud Unit, the local agency shall follow whatever instructions the Fraud Unit staff give in regard to prosecution. If the Fraud Unit decides not to prosecute the case, the FRS-1 will be returned to the local agency with instructions either to refer the case to the Administrative Disqualification Hearing Officer or not pursue the case for a determination of fraud, in which case the overissuance should be handled as a client overissuance. When the case has been accepted

for prosecution there shall be no further referral to the Administrative Disqualification Hearing Officer by the local Case Manager.

If an alleged fraudulent overissuance is accepted for prosecution and the client enters into a diversion agreement, a finding of fraud is not made. As a result, the individual cannot be disqualified, nor can the amount of the overissuance be coded as fraud on the KAECSES system. These claims must be coded as client errors. In addition, the alleged fraudulent overissuance can not be referred for an administrative disqualification hearing for the purpose of a finding of fraud. For these reasons, it is suggested that a disqualification consent agreement be obtained when individuals enter into diversion agreements. Only when a disqualification consent agreement has been signed can the claim be coded as fraud and the individual disqualified from the program.

Whenever possible, persons referred to the Fraud Unit should not receive notification that the case is under investigation prior to a determination by the Fraud Unit regarding the action to be taken. When responding to client inquiries concerning suspected fraud overpayments, EES staff should simply advise the client that the medical case is "under administrative review." Any involvement by the Fraud Unit should not be mentioned to the client.

08460 Fraud Unit Referral - Making the Referral, Fraud Unit Referrals made to the Fraud Unit shall be made by use of the form FRS-1.

NOTE: Alleged Fraud in Medical Assistance - All instances of alleged client fraud in medical assistance shall be referred to the Fraud Unit via form FRS-1. All procedures in ^8440^ for cash assistance Fraud Unit referrals are applicable except there is no financial threshold determination, referral for an Administrative Disqualification Hearing is not applicable, and signing a disqualification consent agreement is not appropriate.

08480 Imposition of Disqualification Penalties -

8481 Cases Referred to Local Fraud Unit -

8481.01 - Individuals found guilty of civil fraud or criminal fraud by a court of appropriate jurisdiction shall be disqualified for the length of time specified by the court. If the court fails to impose a disqualification period, a disqualification period shall be imposed in accordance with KEESM 11221, unless contrary to the court order. If a disqualification is ordered, but a date for initiating the disqualification period is not specified, the disqualification period for currently eligible individuals shall be initiated within 45 days of the date the disqualification was

ordered. The disqualification period is initiated by the sending of the notice. The notice must be sent within 45 days, with the disqualification starting the month following the month in which the notice is sent (or should have been sent in cases where the agency does not act timely to disqualify the individual). Any other court-imposed disqualification (including those which are a result of signing a disqualification consent agreement in cases that enter diversion or those in which the court fails to specifically impose a disqualification period) shall be initiated within 45 days of the date the court found the individual guilty of civil or criminal misrepresentation or fraud. For fraudulent individuals not currently eligible, disqualification periods shall be initiated by notifying the household of the fraud and the specific time period established for disqualification. The disqualification period for individuals not currently eligible shall also be established within 45 days of the date the disqualification was ordered, or within 45 days of the date the court found the individual guilty of civil or criminal fraud as described above. The Case Manager is responsible for notifying the fraudulent individual of the disqualification period and the effect on the remaining household members, if any.

8481.02 - Once a disqualification period has been imposed against the fraudulent individual, the period of disqualification shall be initiated and shall continue uninterrupted until completed regardless of the eligibility of the fraudulent individual's household. The fraudulent individual's household shall continue to be responsible for repayment of the fraudulent overissuance regardless of its eligibility for program benefits.

8481.03 - If the agency fails to act timely to disqualify the fraudulent individual, the individual can only be disqualified to the extent that the disqualification period has not elapsed. An agency error claim SHALL NOT be established for any overissuance resulting from the fraudulent individual participating in the program when he/she should have been disqualified.

08500 Fraud Overpayment Recovery -

8510 Fraud Overpayment Recovery - The remaining household members, if any, shall begin repayment during the period of disqualification imposed by the court or the ADHO. The repayment agreement shall inform the remaining household members of:

8510.01 - The amount owed;

8510.02 - The period of time the overpayment covers;

8510.03 - The repayment methods that are available; and

8511 - The household shall have 10 days from the date the notice is mailed to return the completed repayment agreement. If the household fails to return the completed repayment agreement in the time allotted, benefit reduction shall be imposed in accordance with KEESM 11126.1(4), if repayment is not otherwise established by a court or with the Fraud Unit. In addition, if the household agrees to make repayment but fails to do so, benefit reduction shall be automatically imposed. All actions to invoke benefit reduction when a household has not been making agreed upon repayments must be coordinated with local Fraud Unit Staff. If benefit reduction is invoked, adequate notice only is required.

All repayments shall be made in accordance with established procedures in KEESM 11126.1(4) for cash repayment, monthly installments or benefit reduction.

08520 Reversed Disqualifications - In cases where the determination of fraud is reversed by a court of appropriate jurisdiction, the individual shall be reinstated if otherwise eligible. An underpayment shall promptly be made for any assistance which was lost as a result of the disqualification.